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HEALTH INSURANCE PROGRAMS AND PLANS OF WESTERN EUROPE

A SUMMARY OF OBSERVATIONS [1]

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Among the most conspicuous aspects of postwar reconstruction in Western Europe are the attempts to establish broad social security programs with particular emphasis on health security. Data recently gathered from personal interviews and documents collected in England, France, Belgium, Sweden, Denmark, and the Netherlands reveal the scope and direction of the changes effected or proposed in these countries during or shortly after the war. In all these countries, legislation has been enacted to increase the protection afforded against risks of income loss from sickness, maternity, and permanent disability and to remove or reduce the financial obstacles to preventive, diagnostic, and therapeutic medical care.

All six countries visited—even Sweden which was not an active participant in World War II—have emerged from experiences that severely tested the strength of their social, political, and economic institutions. Yet far from losing faith in their social insurance programs, the people of these countries have united in efforts to expand these programs or other provisions for health security or both.

The two countries (England and Sweden) that escaped invasion and occupation by the German army have formulated comprehensive programs for health and medical care and have discarded all the income and occupational restrictions that formerly limited the coverage of their health insurance programs. The British Government took prompt steps to effect the far-reaching Beveridge proposals—published

[1] From the Divisions of States Relations and Public Health Methods.

The authors gratefully acknowledge the services of E. B. Kovar, Martha D. Ring, and Arthur Weissman in selecting, summarizing, and collating data.

in 1942 while the war outlook was darkest—and, before the close of 1946, Parliament had enacted laws for administering and financing social security programs for the entire population, removing the anomalous restrictions of earlier piecemeal legislation. Within the same period, Sweden took almost parallel steps toward health security and amended its universal old-age and invalidity program to authorize benefit levels that would make supplementary assistance unnecessary for the great majority of pensioners.

The occupied countries (France, Belgium, Denmark, and the Netherlands) face immediate problems of stabilizing currency, restoring productive capacity, and eradicating the effects of low nutritional standards on the health and morale of the population. Their current social security plans appear somewhat less extensive than those of England and Sweden, but they, too, are pursuing the broad objectives of their governments-in-exile or underground resistance forces, which placed social security among the foremost of their postwar aims.

In three countries (England, Sweden, and Denmark), the health security programs will be or already constitute broad, integrated services for public health, hospitalization, and other medical care. In three (France, Belgium, and the Netherlands), the expansion of health insurance coverage and the scope of medical and other social insurance benefits is receiving the greater initial emphasis.

Some of the more significant details of prewar, existing, and proposed social insurance programs for medical care and compensation of income loss during temporary and permanent disability are summarized below for each of the six countries visited.[2] No two countries follow identical paths; no two are wholly alike in social, political, or economic traditions or objectives. From their wartime or postwar health insurance programs, however, emerge general directions or patterns that characterize two or more countries.

1. All six countries initially based their nation-wide health insurance systems on voluntary mutual benefit societies or sickness funds, which, when they met certain requirements for Government approval, were responsible (except in the Netherlands) for administering cash benefits under the insurance system and (except in England) for administering medical benefits. In their new health insurance programs, two countries have abandoned use of these approved societies: In England, their functions in paying cash sickness benefits will be transferred to central, regional, and local government agencies; responsibility for administering medical benefits will be carried by executive councils, regional boards, and hospital management committees. In France, primary and regional funds have been set up with the responsibilities and much of the character of the funds which mutual benefit

[2] No details are included on the workmen's compensation programs of these countries.

societies established for the administration of the earlier system. The four countries (Belgium, Sweden, Denmark, and the Netherlands) that retain sickness funds or mutual benefit societies in their national health insurance systems have developed detailed requirements for their operations.

2. All six countries—whether they discard or retain the approved societies or sickness funds in their national health insurance programs—urge the use of these organizations or similar associations to provide types of protection that will supplement, on a voluntary basis, that afforded by the national system.

3. All six countries seek to avoid "bureaucratic" control of health insurance administration by decentralizing operations, as well as by providing for administrative bodies and advisory groups which, by and large, include representatives of the general public, insured persons, management and labor, and the medical professions.

4. When their proposed programs are in effect, two countries (England and Sweden) will provide medical benefits for the entire population, while three countries (France, Belgium, and the Netherlands) still restrict the coverage of their compulsory health insurance programs to designated occupational or income groups. Denmark will retain income restrictions and the quasi-voluntary aspects of health insurance coverage in its national program. All six countries have developed compulsory invalidity insurance programs of wide coverage.

5. Four of the six countries (all but France and the Netherlands) have removed or propose to remove part of the costs of medical benefits from the health insurance program by substantial subsidies from general tax revenues.

6. All countries permit free choice of practitioners among those who agree to serve in the health insurance system, and all emphasize the "family doctor" principle. Three countries (England, Denmark, and the Netherlands) use a capitation basis for paying general practitioners under the health insurance system, though new provisions in England leave the way open for a supplementary salary, and in Denmark fees for service are a common alternative to capitation payments. Three countries (France, Belgium, and Sweden) use the fee-for-service method of remunerating general practitioners, though Belgium has an additional provision for capitation, and in Sweden some salaried public doctors get fees for serving insured as well as other patients. No specific pattern for paying specialists appears predominant, except that the fee-for-service system is common when specialist care is not included as part of the hospital benefit.

7. The new laws or existing programs of four countries (all but France and the Netherlands) provide that public funds shall meet all or most costs of expensive illness requiring hospitalization and the

services of surgeons and other specialists, removing nearly all financial barriers for these forms of medical benefits. Three of the countries (France, Belgium, and Sweden) require that insured persons bear some part of the costs of general practitioner's services and medicines, by providing reimbursement for only part (two-thirds or three-fourths in Belgium, three-fourths in Sweden's new program, and four-fifths in France) of the fees for service set forth in an approved fee schedule.

8. When an insured person receiving cash sickness benefits has a dependent wife and children, allowances for these dependents are, or will be, payable in three countries (England, France, and Sweden). The benefits payable for illness are, or will be, virtually unlimited in duration in all countries, either by assimilation with disability benefits (England), or by transfer to invalidity pensions (all but England) and subsequent transfer to old-age pensions. Public funds contribute toward cash sickness benefits in all but two countries (France and the Netherlands).

9. In all six countries, medical benefits for insured persons and their dependents, provided or proposed, include most essential services and supplies, though in all countries the existing or recently authorized programs face questions of numbers and distribution of personnel and facilities necessary to meet their health objectives.

10. All six countries are approaching their health insurance programs with due allowance for the need to work out step by step administrative and other details of health security programs in cooperation with the professional and technical personnel concerned and the persons covered by these programs. All recognize that success will depend on that cooperation and on the extent to which national income and productive capacity can be maintained at or raised to adequate levels.

11. In all six countries, medical practitioners and others concerned with health security problems agree, in general, on the value of insurance devices and the use of public revenues to finance medical care programs. The differences of opinion voiced on the need for expanding these programs relate to the details of operation, the income level of the population to be covered, and the rates and methods of remunerating practitioners.

12. Either in conjunction with health insurance or as separate health security programs, all six countries propose to expand tax-supported services for maternity care; child health and welfare; dental care; early case finding and treatment of chronic conditions and tuberculosis, venereal, and other communicable diseases; immunization and vaccination; medical care of assistance recipients and old-age and invalidity pensioners; care of convalescents; and hospitalization. All are working out hospital plans to group small local

units around central well-equipped establishments, so that persons in all parts of the country may have relatively prompt access to the most advanced techniques in the diagnosis and treatment of illness. These programs are cited in the following summaries only insofar as they throw light on the types of medical and maternity services proposed or provided in the health insurance system.

ENGLAND AND WALES

Compulsory health insurance was inaugurated on July 15, 1912, under the provisions of the National Insurance Act of 1911. From 1919 to 1941, amending legislation increased benefits, coverage, and contributions. During 1944, 1945, and 1946, basic recommendations in the PEP (Political and Economic Planning) report of 1937, the Beveridge report of 1942, the reports issued by the Nuffield Provincial Hospitals Trust in 1945 and 1946, and in other studies were enacted into law.

The National Insurance Act of 1944 provides, among other things, for the transfer of all national health insurance functions, except the administration of medical benefits, from the Ministry of Health to the Ministry of National Insurance, a new agency created by the act and established in 1945. The new Ministry will be the central body responsible for cash benefits for wage losses during illness; widows', orphans', and old-age pensions and supplementary pensions; unemployment insurance and assistance; and certain phases of workmen's compensation. In 1945, the Family Allowance Act gave the Minister of National Insurance additional functions, and, in 1946, the National Insurance (Industrial Injuries) Act placed an enlarged workmen's compensation program under the new Ministry. An integrated and extended system of cash benefits is incorporated in the National Insurance Act of 1946, providing substantially increased payments for wage losses during illness and increasing the coverage and benefit levels for these as well as other types of social security.

In 1946 the National Health Service Act was passed, authorizing a comprehensive medical care program under the Ministry of Health. The program, which the Government hopes to place in operation in 1948, is to provide all types of medical services for all persons in the population. On November 6, the day the National Health Service Act for England and Wales received royal assent, a similar bill for Scotland was introduced in the House of Commons.

The broad and integrated social security program adopted for England and Wales embodies all major objectives of the Beveridge plan. It assures some continuing income when family resources are reduced by unemployment, pregnancy, illness, disability, or death of all who work for a living, with supplementary benefits for the dependent members of the family. It provides income for all persons who are permanently disabled and for all aged persons, and distributes over the population as a whole some of the financial burden of rearing children by paying family allowances to all persons who have more than one young child to support. It plans, furthermore, to provide free medical, dental, nursing, and hospital treatment and pharmaceutical supplies for everyone, regardless of income level or insurance status. The effective dates of the National Insurance Act of 1946 and National Health Service Act will be set by the ministries responsible for administration.

Administration

Medical benefits are to be administered nationally by the Ministry of Health assisted by a Central Health Services Council. Regional hospital boards and

local hospital management committees will administer hospital and specialist services; local executive councils will administer the provision of general practitioner, pharmaceutical, dental, and ophthalmic services; local health authorities will be responsible for providing preventive and domiciliary services, and for constructing and maintaining health centers and clinics. Basic regulations governing the National Health Service will be promulgated by the Minister of Health and reviewed by Parliament. Certain regulations governing superannuation, transfer, and compensation of personnel must be approved by Parliament before promulgation.

The administration of cash sickness benefits will be under the jurisdiction of the new Ministry of National Insurance. Approved societies will no longer participate in the compulsory system. Benefit disbursements will be made by the regional and local officers of the Ministry, who pay cash benefits under the other social security programs.

Coverage

Comprehensive medical services will be available to all persons in the population, irrespective of insurance status, age, employment status, or income level. Provision is made for persons, who so desire, to purchase additional services, e. g., special appliances, or private-room care in nursing homes; moreover, all those who wish to receive their medical care and treatment outside the National Health Service may purchase such services through their own arrangements. Under the new National Insurance Act, coverage for cash sickness benefits will include employed (and self-employed) persons over school-leaving age and under pensionable age, without income limit. Persons of working ages who are not in the labor market will be subject to contributions and eligible for other insurance benefits, but will not receive cash sickness benefits.

Until the National Health Service Act becomes effective, coverage for medical benefits remains limited to persons between the ages of 16 and 70 who are employed under a contract of service in manual labor or—if engaged in nonmanual employment—who have a yearly income of not more than £420, without provisions for the care of dependents of insured persons. The Annual Report of the Ministry of Health for 1945 indicates that the total number of compulsorily insured persons in England and Wales was 22,006,000 as of December 31, 1943, or about 53 percent of the total population.

Financing

Under the new National Insurance Act, cash sickness benefits will be paid out of the National Insurance Fund from which other social insurance payments are made. The fund will be made up of contributions of insured persons and employers and of supplemental Exchequer contributions and grants. From these contributions, amounts ranging from 6d. (10¢) to 10d. (17¢) per insured person will be allotted to the National Health Service, even though medical services are to be provided irrespective of insured status—on the theory that the medical service will result in savings to the fund in expenditures for cash sickness benefits. The source of all funds for the National Health Service and the annual amounts estimated to be needed during the early years of operation are (*4*, p. iv):

Source	Amount, in pounds sterling	Percent of total
Total	152, 000, 000	100
National Insurance Fund	32, 000, 000	21
Local authorities	10, 000, 000	7
Exchequer (net amount)	110, 000, 000	72

Annual expenditures for health services during the early years of operation are estimated as (4, p. iii):

Type of expenditure	Amount, in pounds sterling	Percent of total
Total	152,000,000	100
Hospital and specialist services	87,000,000	57
General practitioner, pharmaceutical, dental, and other services [1]	53,000,000	35
Local health authorities' services	12,000,000	8

[1] Includes superannuation and special compensation for medical and dental practitioners.

Single weekly contributions, varying with age, sex, source of income—and for employed persons, with rate of remuneration—will be paid for all cash sickness and invalidity, unemployment, maternity, survivors', and old-age benefits. For employees, the initial weekly rates will range from 2s. 2d. for girls under age 18 to 4s. 7d. for men aged 18–70 who earn more than 30s. a week; the weekly contributions of employers for their employees will range from 1s. 9d. to 5s. 9d. The range for self-employed persons will be from 3s. 1d. for girls under age 18 to 6s. 2d. for men aged 18–70, and for persons who are not gainful workers, from 2s. 3d. to 4s. 8d. These weekly contributions will be paid, as at present, by affixing insurance stamps to contribution cards. The Exchequer supplement will range from 4d. per week for girls to 1s. 1d. for adult males.

Until the new laws are in operation, health insurance contributions remain separate from those for the other social insurance programs and for insured persons, with certain exceptions, range from 2d. a week for juveniles to 5½d. for employed men aged 16–65; in general, the employers' contributions equal those of their insured employees, and the Government supplements the health insurance funds by periodic grants. In 1944, approximate receipts for national health insurance totaled £51,093,000. Of this amount, £34,821,000 represented contributions by employers and employees; £9,867,000 consisted of Parliamentary grants; and interest and miscellaneous receipts accounted for £6,405,000.

Regulations on remuneration of practitioners under the National Health Service Act of 1946 have not yet been promulgated, and agreements have not as yet been made between practitioners and the committees provided for in the act. It is believed, however, that capitation will be the basic method of payment. As under the existing program, patients will have the right to choose their doctor, and doctors will be free to accept or reject any persons who ask to be placed on their panels. Regulations may limit the number of patients on a doctor's list, and provision is made for limiting the number of practitioners in an area. Any physician whose name is entered on any list for the provision of medical care on the day the act becomes effective will be entitled to compensation (payable at retirement, death, or other specified time) for any loss suffered through inability to sell his practice, since the act prohibits such sale.

Until the new system is in operation, insurance practitioners are paid quarterly on a capitation basis, at an annual rate of 15s. 6d. per patient. Under certain conditions, mileage rates are paid for travel. Insured persons choose their own doctors from lists of insurance doctors, and the number of patients on a doctor's list is limited by regulation.

Cash Benefits

Sickness.—Under the new National Insurance Act, the cash benefit for sickness will be the same as for unemployment and will be payable, after a 3-day waiting

period, to insured persons above school-leaving age and below pensionable age who meet contribution requirements. The weekly rates will be (*2*, p. 80):

Sickness benefit	*Weekly rate*
Married man with wife not gainfully employed	42s.
Single man or woman	26s.
Married man with wife gainfully employed	16s.
Married woman gainfully employed	16s.
Allowance for adult dependent, where payable	16s.
Allowance for first child	[1] 7s. 6d.

[1] This benefit is provided for the child ineligible for children's allowances under the Family Allowance Act of 1945.

The duration of the sickness benefit will be 52 weeks for persons with less than 156 contributions to their credit. For other insured persons, the duration can be unlimited, since no distinction is to be made between short-term and permanent incapacity for work.

Until the new provisions are effective, the rates of benefits are substantially lower (*12*, par. 33):

Insured person	*Weekly benefit rate*	
	Sickness	*Disablement*
Man	18s.	10s. 6d.
Unmarried woman	15s.	9s.
Married woman	13s.	8s.

Reduced rates are paid if 26 but less than 104 weekly contributions have been made, and the duration of cash sickness benefits is limited to 26 weeks. Disablement benefits, at a lower rate, are continued as long as the insured worker remains incapable of working and until he or she reaches pensionable age.

Maternity.—The new law in England and Wales will provide a maternity grant of £4 and either a maternity or a housekeeping attendant's allowance to any woman, if a general practitioner certifies that she has been confined and if she or her husband meets the contribution requirements. The allowance for a housekeeping attendant is to be 20s. a week, payable for a maximum of 4 weeks beginning with the date of confinement. The maternity allowance will be 36s. a week for 13 weeks beginning with the sixth week before the expected week of confinement. Regulations may disqualify a woman from receiving the maternity allowance for periods in which she engages in gainful work or if she fails without good cause to submit to medical examination. Until the new law is in operation, the maternity benefit is a lump sum of 80s. payable to an employed woman insured in her own right, or 40s. if only the husband is insured.

Medical Benefits

The new law authorizes free provision of all types of medical services for all persons: services of general practitioners and specialists; hospitalization (including in-patient and out-patient services, care in mental hospitals, and sanitariums); home nursing; maternal and child health; pharmaceutical, dental, and ophthalmic care; convalescent treatment; medical rehabilitation; vaccination and immunization; and spectacles, dentures, and appliances. Medical and preventive services are to be expanded by the establishment of adequately equipped health centers for use by general practitioners and local health authorities. Free hospitalization will be provided in all institutions except private nursing homes. Under the new act, the Minister of Health will take over all public and all voluntary (private, nonprofit) hospitals; all services of hospital personnel, including surgeons and other specialists, will be provided free of charge. Patients who so desire may make their own financial arrangements for private

rooms in these hospitals, if facilities are available, and for services in private nursing homes.

In scope, the medical benefits authorized under the new law are in sharp contrast with the limited benefits (general practitioner services and routine medicines) under the national health insurance system. Under that system, additional benefits (including dental, opthalmic, convalescent home care, surgical appliances, etc.) have been permitted, however, for approved societies with appreciable surpluses at quinquennial valuations of their funds. Thus, the amount and type of additional benefits have varied according to the financial status of the society in which the insured person was a member. Likewise, no provision has hitherto been made for hospitalization or for specialists' services for insured persons, except as additional benefits from approved societies with adequate financial reserves.

FRANCE

When the war broke out in 1939, France had social security laws providing workmen's compensation; old-age, invalidity, and survivors' pensions; cash and medical benefits for sickness; death benefits; and maternity insurance, including special allowances for nursing mothers and a system of milk vouchers for other mothers. Compulsory cash sickness benefit and medical care insurance was first established, in 1930, under a law enacted in 1928 providing, in addition, for maternity, invalidity, survivors', and death benefits. The law of 1928 was administered largely by approved mutual benefit societies, which established separate local and regional funds for each type of insurance benefit; these funds collected the contributions and distributed the benefits fixed by law.

Although some changes were made in this system of social insurance by the Pétain government during the German occupation, it continued to operate in substantially the same form until the liberation of France in 1944. Soon after liberation, laws were passed setting up a more comprehensive system of social security. The new legislation also provided extended coverage, increased benefits, and a new administrative structure for the social security system. The two major statutes which accomplished these changes were the Ordinance of October 4, 1945, establishing a new system to finance and to administer social insurance benefits, old-age grants, compensation for industrial accidents and occupational diseases, family allowances, and single-wage allowances (special payments to families in which there is only one wage earner), and the Ordinance of October 19, 1945, organizing a new social insurance system for persons employed in nonagricultural occupations covering sickness, maternity, invalidity, old-age, and death benefits. Most of the provisions of both laws went into effect on July 1, 1946.

Further extension of social insurance to cover virtually the entire French population was provided for in a law passed on May 22, 1946; it was stated in the text of the law, however, that most of its provisions were not to come into force until the French industrial production index had reached 125 percent of that of 1938. In September 1946, this index was about 70 percent of 1938.

Administration

Health insurance, including benefits during sickness, maternity, and invalidity, is administered in France through a system of local and regional bodies called social security funds. The insurance system is based wholly on contributions from insured individuals and their employers. Government participation is limited to exercise of technical and financial supervision.

The function of the local bodies, or primary funds, in the administration of health insurance is to award cash and medical benefits for sickness, maternity,

and death benefits. In the local administration of health insurance, the primary funds supersede the formerly approved mutual benefit societies. Primary funds, set up on a provincial (départementale) basis, are governed by administrative councils on which two-thirds of the seats must be held by representatives of insured persons. The remaining third of each primary council's membership must represent employers, family associations,[3] and professional social security experts. Depending on the number of members in a specific fund, its council has either 12, 24, or 36 members. Primary funds must create local sections for each group of at least 2,000 insured persons. In large cities, in addition to ordinary primary funds with 12- or 24-member councils, a central primary fund is established with 36 or 48 members on its administrative council. Two doctors are attached to primary fund councils in an advisory capacity.[4]

Regional funds, replacing the former regional unions of funds, administer health insurance for areas larger than a province. They are responsible for equalizing and reinsuring the risks covered by the primary funds in their area, organizing and directing medical control, and administering invalidity pensions. Regional funds are managed by 26-member councils, composed of representatives of the primary funds in the region.

A national social security fund, replacing the General Guaranty Fund of the prewar system, equalizes and reinsures the risks carried by the regional funds. Its administrative council is made up of representatives of the Council of State, the several ministries concerned with social security, the regional funds, the special funds for administering family allowances, and other national agencies. The representatives from the regional and family allowance funds must be elected.

A General Social Security Directorate in the Ministry of Labor and Social Security supervises the activities of primary, regional, and national funds. It carries out this task through regional social security directorates with supervisory authority over the regional and primary funds. These directorates are also responsible for enforcing the rules of affiliation and for payment of contributions to the funds. A Superior Social Security Council is established to aid the Minister of Labor by advising on all social insurance matters which he may refer to it.

Medical supervision of the work of primary funds is carried out by special medical advisers under a regional medical adviser appointed by each regional fund.

Private mutual benefit societies have lost their compulsory insurance functions under the new postwar legislation. An Ordinance of October 19, 1945, on the status of mutual societies, leaves them free, however, to provide voluntary insurance and benefits supplementing those of the compulsory system.

Coverage

The Ordinance of October 19, 1945, makes compulsory health insurance applicable, with few exceptions, to all persons living in France who are employed in nonagricultural occupations (including self-employed), regardless of income. Formerly, manual workers were covered for compulsory insurance regardless of their yearly income, but other workers were subject to the compulsory system only if their annual income did not exceed Fr. 120,000 (about $1,020). The spouse of an insured person and his nonworking children under age 16, in addition to

[3] An Ordinance of March 3, 1945, promulgated by the Ministry of Population, gives family associations new legal status; they are defined as groups created for the moral and material protection of the general interests of families.

[4] More recent information indicates some changes in composition and methods of selecting administrative councils of social security funds; higher maximums for cash sickness, maternity, and invalidity benefits; and an increase in the maximum wage on which insurance contributions for nonagricultural workers are based (Secrétariat d'État à la Présidence du Conseil et à l'Information, Direction de la Documentation: La Sécurité Sociale en France, Première Partie: Notes Documentaires et Études, No. 451; October 25, 1946).

certain classes of his dependent relatives, are covered for medical benefits by his contribution. If the insured person's children are invalids, apprentices, or are continuing their education, they are covered for medical benefits by his contribution even if they are older than 16.

Special categories of workers such as miners, railway men, Government employees (national and local), merchant seamen, and those in the gas and electricity industries retain their own occupational insurance schemes and do not come under the general system. Agricultural and forestry workers are insured through a special system of funds under the supervision of the Ministry of Agriculture.

The new law of May 22, 1946, extends benefits of the compulsory social insurance system to virtually the entire population of France. In addition to employed persons, businessmen and owners of industrial and agricultural undertakings are covered, as well as those engaged in occupations from which they receive no income and those with no occupation. The only persons not covered by this act are those covered by separate occupational systems.

Financing

Payments for all social insurance benefits, including health insurance, are made by the funds out of contributions from employers and insured individuals. Under the Ordinance of October 4, 1945, the total contribution for all benefits for those engaged in nonagricultural work, is 12 percent of wages, based on a set maximum annual wage. Half the contribution is paid by the employer, the other half by the employee.[5] The employer pays the total contribution to the primary fund, deducting the employees' share from their wages. The primary fund then transmits to regional and national funds the part of the contributions due them, on an apportionment basis determined annually by the Minister of Labor and Social Security. Employers with less than 10 employees and the self-employed pay contributions on a quarterly basis; all other employers and the voluntarily insured pay on a monthly basis.

Doctors who work under social insurance are paid on a fee-for-service basis. Insurance patients have free choice of physician. Fee schedules, set by agreements between insurance funds and local medical societies, become effective after approval by a special national commission composed of representatives of the funds, medical practitioners, and the ministries concerned. If agreement on fee schedules cannot be reached locally, this commission fixes the rates. Usually, the insurance doctor is paid directly by the patient, and the latter is then reimbursed by the funds in terms of the established fee schedules. The fee for a specific service performed by an insurance doctor is determined by the product of a key-letter (which denotes the type of treatment, e. g., "K," for specialist and surgical care, and the value of which is established for each province) and a coefficient (representing the relative value of the treatment itself) set nationally and published in an official list of professional services performed by all classes

[5] The new law of May 22, 1946, not yet in effect, increases the general contribution rate for groups covered for all social insurance benefits to 16 percent. Nonagricultural employees continue to pay a 6-percent contribution, but their employers must pay 10 percent. Exempt from contributions are dependent children, unemployed persons registered at an employment bureau, and various classes of pensioners; these groups, except the unemployed, receive only medical benefits for maternity and sickness. Only employed persons and those on the same footing and registered unemployed are entitled to daily cash benefits. The contribution basis for nonagricultural employees remains the same (Fr. 120,000 a year); for other gainful workers in the same occupations, it is taxable income from their occupations, with certain minimums; for nonworking spouses of these two groups, it is the maximum old-age pension payable to insured persons at age 65; for other contributors, it is either net taxable income (for those subject to income tax) or half the basic wage of the lowest-paid group of manual workers in the provincial capital. The law also sets contribution bases for gainful workers in agriculture and forestry, but retains their separate funds; and authorizes changes in the administrative councils of social security funds.

of medical practitioners. Special regulations in March and April 1946 increased from 80 percent to 100 percent the reimbursement to insured patients for any treatment, whether by a general practitioner or specialist, on the established list of professional services with a coefficient of 50 or more. Also, since May 1946, doctors are prohibited by law, except in specified circumstances, from charging insured patients more than the scheduled fee for a specific service. All expenses for medical treatment in connection with maternity or long-term illness are reimbursed 100 percent. The value of "K" in Paris and other large cities is now Fr. 75.

Hospital fees for bed, board, and other services for insured persons and their dependents are arranged, in general, by contract between funds and particular hospitals. The patient pays the hospital directly and is reimbursed up to 100 percent under the new regulations. The charges for general practitioner services in a hospital are added to the patient's bill, and he is similarly reimbursed by the funds.

The expenditure in 1945 for cash sickness and medical benefits is shown by the following table (*18*):

Type of expenditure	Amount, in francs	Percent of total	Type of expenditure	Amount, in francs	Percent of total
Total	6,291,000,000	100.0	Drugs	888,000,000	14.1
			Dental care	237,000,000	3.8
General practitioner services	867,000,000	13.8	Hospital and free care	773,000,000	12.3
Surgical care	348,000,000	5.5	Daily cash benefits	3,005,000,000	47.8
			Medical control	173,000,000	2.7

Cash Benefits

Sickness.—The daily cash benefit for short-term illness, under compulsory insurance, is equal to one-half the basic daily earnings of the insured person, up to a maximum of Fr. 150 a day. If he has three or more dependent children, the rate is increased to two-thirds the daily earnings from the thirty-first day after the illness begins. If institutional treatment is required, the daily benefit is reduced by fifths, according to the number of dependents of the insured (by three-fifths if he has no dependents). For long-term illness, a monthly cash allowance 30 times the daily grant for short-term illness is paid by the funds, up to a maximum of Fr. 4,500 a month, or Fr. 6,000 if the insured has three children. If hospital treatment is required, the same reductions are made as in the case of short-term illness. The daily benefit for short-term sickness is limited to 6 months for the same illness; for long-term illness, the duration of the benefit may extend to 3 years. To receive cash benefits for long-term sickness, the insured person must undergo a special examination before the end of the third month of illness. This examination is made by the attending doctor and the medical adviser of the fund. To get cash sickness benefits, the insured person must notify the primary fund of his condition within 3 days after the onset of the illness.

Invalidity.—Any insured individual whose earning capacity has been reduced by two-thirds may receive an invalidity pension, payable quarterly. If he is able to do part-time work, his annual pension amounts to 30 percent of his average annual wage for the preceding 10 years; if he is totally incapacitated for work, he receives 40 percent of the same basic wage; if he requires the constant assistance of an attendant, he gets a special increment of 20 percent of the 40-percent pension for general incapacity. In no case may this increment, however, exceed Fr. 9,000, nor may the total annual pension be less than Fr. 7,200. At the age

of 60, the invalidity pension is superseded by an old-age pension which cannot be less than the invalidity pension it replaces.

Maternity.—The daily cash allowance to insured women for maternity, calculated on the same basis as the cash sickness benefit, is payable for 6 weeks before and 8 weeks after confinement. If confinement results in medical complications, the woman receives sickness benefit instead. The funds fix the monthly allowance to an insured woman for nursing her own child; if the attending physician certifies that she is unable to nurse it, she receives milk vouchers, the value of which cannot exceed 60 percent of the nursing allowance. The amount and duration of the milk-voucher grant is fixed by the attending doctor. Allowances for prenatal and postnatal examinations are also provided in amounts established by each fund. For maternity benefits, the insured person must have been registered as insured for not less than 10 months before the probable confinement date, and provided she ceases all gainful work during the benefit period.

Medical Benefits

Compulsorily insured persons are covered for general and specialist medical care; surgical operations; dental treatment (including necessary dentures); costs of drugs and appliances; laboratory analyses; medical examinations at stated intervals; maintenance and treatment in hospitals, clinics, and dispensaries (and in private nursing homes if medically necessary); and ambulance service. The period for which the funds will pay in full for medical care in connection with tuberculosis treatment has been extended to 10 years (it was 3 years until 1945). Dependents of invalidity pensioners receive medical benefits for sickness and maternity.

Medical benefits for maternity include all expenses for treatment during pregnancy and confinement, provided the woman notifies the primary fund that she is pregnant 4 months before the probable date of confinement; if not, the fund will bear only 80 percent of the costs.

The funds reimburse insured patients for 80 percent of the cost of ordinary drugs, and some special drugs; for other special drugs, the funds repay only 40 percent.

BELGIUM

Before the outbreak of World War II, Belgium had social security programs covering the risks of old age, invalidity, sickness, maternity, costs of rearing children, occupational accident and disease, costs of medical care, involuntary unemployment, and death, for persons dependent on wages or salary for a livelihood. All but a few of these programs, however, were on a voluntary basis, and functioned in accordance with the relative financial resources of various insurance societies, occupational groups, and geographic areas. Believing that social solidarity required a closer integration of provisions to protect workers against involuntary wage loss and costs of health care, representatives of workers and employers met secretly in Belgium as early as 1941 to plan a comprehensive, compulsory social security program, broad in coverage of persons and risks and liberal in terms of benefits provided, to be financed by employer and employee contributions and general revenues. The new program was enacted into law on December 28, 1944, and its administrative agency, the National Social Security Office, was established on January 1, 1945, less than 4 months after liberation from German occupation. The compulsory health insurance program became effective on April 1, 1945, supplanting the voluntary system which had been in operation since 1894.

Administration

To administer national aspects of the health insurance program, a Government agency, the National Sickness and Invalidity Insurance Fund, has been set up in the Ministry of Labor and Social Welfare. The Fund, headed by an Administrator-General, is administered by a National Administrative Committee consisting of representatives of labor, management, unions of the local mutual benefit societies, and Government Departments (Public Health, Finance, and Labor and Social Welfare). The National Administrative Committee makes no decisions on medical, dental, or pharmaceutical matters without the advice of its appropriate technical advisory councils; its functions are to distribute the Fund's resources, develop and effectuate regulations, and propose amendments to laws and legislative orders.

Provincial advisory commissions (composed of representatives of labor, management, and local mutual benefit societies) supervise the operations of provincial control centers, which, in turn, supervise the local health insurance organizations. These insurance organizations are the approved societies which formerly administered the voluntary system. Persons covered by the system must enroll either in an approved benefit society of their choice or in the regional office of the National Sickness and Invalidity Insurance Fund of the area in which they live. The benefit societies and regional offices determine eligibility, pay cash benefits for sickness, maternity, and invalidity, and reimburse insured persons for medical expenses, including expenses for care of their eligible dependents.

Coverage

Coverage is compulsory for nearly all persons bound by an employment contract. About half the 8,300,000 persons in the Belgian population receive their medical care through the health insurance system. In 1946 the system had about 1,700,000 insured persons—20,000 enrolled as members of regional offices, and 1,650,000 as members of the 2,500 approved benefit societies, which are federated in five groups (Socialist, Catholic, Professional, Neutral, and Liberal). With eligible dependents of insured persons—young children and dependent parents aged 55 or over—the number of persons eligible for medical benefits totalled about 4,000,000. Among the excluded groups are the self-employed; persons engaged in agriculture, domestic service, fishing, services in inland navigation, family employment, public employment; merchant seamen; and employees of the National Belgian Railway Company. All excluded groups may later be included by royal order, and coverage for self-employed persons is planned for 1947.

Financing

For each quarter, employers send to the National Social Security Office the total amount of employer and employee contributions payable for the period toward the whole social security program. That Office then sends to the National Sickness and Invalidity Insurance Fund the amounts allotted to health insurance, and the Fund, in turn, distributes to benefit societies and regional offices the sums which represent contributions by or on behalf of their members. These sums are determined on the basis of contribution certificates which employers give their employees to indicate the amount of wages from which the employees' health insurance contributions have been deducted. The worker must give or send this certificate to the benefit society or regional office in which he is enrolled to show that his contribution record is in order. The certificates are sent each quarter to the National Sickness and Invalidity Insurance Fund.

Some 140,000 employers contribute for the health and invalidity insurance program 2.5 percent of the wages of manual workers and 2.25 percent of the

salaries of office workers. Insured persons contribute 3.5 percent of their wages if they are manual workers and 2.75 percent of their salaries if they are office workers. For both employer and employee contributions, only the first Fr. 4,000 a month of remuneration is taxable.

The National Government adds a sum equal to 16 percent of total health insurance contributions as a subsidy to improve medical care. In 1945, the Government contribution was Fr. 350,000,000, or about Fr. 87.5 ($1.75) per person eligible for medical benefits. The National Sickness and Invalidity Insurance Fund also contributes toward medical care for certain noncontributing persons and their families (old-age, survivor, and invalidity beneficiaries; families of persons called to the armed forces; and persons involuntarily unemployed).

Under the former voluntary system, members' contributions varied among funds; employers sometimes contributed for their employees who were members of mutual benefit societies organized for specific occupational groups; and the National Government paid approved societies a subsidy which approximately equalled the members' contributions.

Under the new program, doctors, dentists, midwives, and pharmacists signify each year, at the invitation of the National Fund, their willingness to participate in providing medical benefits under the fee schedules established by agreement between the professional organizations and the National Fund. Each union of mutual benefit societies and each regional office has medical advisers on its staff determined in proportion to its membership (1 medical adviser per 25,000 persons eligible for medical benefits). These medical advisers give no medical treatment; they are responsible for seeing that the medical treatment is effective and economical and for authorizing hospitalization and other special medical benefits.

Insured persons pay their own bills for general medical care, and the insurance organization reimburses them for three-fourths of their payments for office calls and two-thirds of their payments for home calls. The insured person pays no fees for hospitalization, care of specialists, or other special benefits, but, on recommendation of its medical adviser, the insurance organization may curtail these benefits in some cases. A lump sum is paid to an insured woman to cover medical costs of a normal delivery unless, barring circumstances beyond her control, she has failed to call in a physician or registered midwife. The insured person is reimbursed for all but a flat amount (Fr. 4) for drugs and medicines included in the list of pharmaceutical products approved as medical benefits.

The insured person has free choice of practitioner among all persons legally authorized to practice the art of healing and may change at will. He likewise can choose among all hospitals or other institutions approved by the Minister of Public Health. As an alternative, he may engage a practitioner or group of practitioners, hospital, or clinic, to furnish his entire health care for 6 months or a year. In that event, the practitioner or organization accepting him for such care receives a periodic capitation payment, which may be supplemented by a small fee for service payable by the insured person. The fee, in general, would represent the amount for which the insured person is not reimbursed by the insurance organization (one-fourth the charge for an office visit and one-third that for a home call). The fee schedule adopted in September 1946 permits variations in fees for service with changes in the average hourly earnings of skilled and unskilled workers. A unit number is assigned to each medical service, representing the factor by which the average hourly wage (Fr. 7 at that time) is to be multiplied to derive the actual fee. Thus, a surgical delivery is assigned a factor of 300, which yields a fee of Fr. 2,100.

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Cash Benefits

Sickness (primary incapacity).—Insured persons are eligible for cash benefits, payable monthly, amounting to 60 percent of their average remuneration in the 4 weeks preceding the onset of illness. The maximum payable is Fr. 3,500 a month. The waiting period is 3 work days for manual workers and 30 days for office workers (by law, the employer is required to give the latter 30 calendar days of sick leave with pay).

Under the former voluntary system, the cash benefit varied among funds, but was at least Fr. 6 a day for men over age 18, Fr. 4 for women, and Fr. 2 for younger persons.

Maternity.—An insured woman receives the equivalent of cash sickness benefits for 6 weeks before and 6 weeks after confinement, provided she leaves work for those periods. Since the maternity benefit is a form of wage-loss compensation, it is paid only to gainfully employed women. Formerly, the cash maternity benefit was a lump sum of Fr. 125, plus a daily benefit of at least Fr. 3 for 6 weeks.

Invalidity.—If, after exhausting rights to cash sickness benefits, an insured person is found to have lost two-thirds of his earning capacity, he becomes eligible for an invalidity benefit equal to one-half his former average daily wage if he has dependents, and one-third if he has no dependents. Invalidity benefits cease when the insured person reaches the age of 65 and qualifies for an old-age retirement pension.

Medical Benefits

Regulations define the medical benefits as continuing medical surveillance aimed at maintaining and improving health; discovery and accurate diagnosis of all abnormal conditions to permit starting the treatment that will restore health and working capacity most rapidly, completely, and economically; and necessary treatment for all pathological conditions discovered. The participating practitioners, persons eligible for care, and insurance organizations must collaborate toward achieving these goals. No limit is set on duration of care, and no waiting period is required.

General care comprises consultations and visits at the office of a general practitioner or specialist; dental care given by a doctor of medicine or licensed or qualified dentist, excluding prosthesis and orthodontia; and pharmaceutical materials. Special care includes surgical operations, services for difficult confinements; examinations by specialists; radiology, laboratory analyses, physiotherapy; hospitalization; spectacles, hearing aids, bandages, and orthopedic appliances; prosthesis, including dental prosthesis and orthodontia; and vocational rehabilitation. Under the former voluntary system, the scope and duration of medical benefits varied among mutual benefit societies. Most of them provided medical and pharmaceutical benefits for at least 2 years and at least 3 months of free treatment for tuberculosis in a sanitarium.

SWEDEN

Sweden, one of the pioneer countries in Western Europe to establish broad programs of social insurance, public assistance, and provisions for health and general welfare, has recently enacted legislation to provide more comprehensive and liberal protection against threats to economic and social security. Under laws (Nos. 431–433) which received royal assent on June 29, 1946, and which will be effective January 1, 1948, the universal compulsory system of old-age and invalidity pensions will require higher contributions and provide larger basic benefits, with supplements, related to need, to take account of geographic variations in the cost of housing and fuel. Contributions will be collected, as they

now are, with income and property taxes, but pensions will no longer be related to contribution records.

Changes in the existing voluntary health insurance system are even more far reaching. On December 18, 1946, the Riksdag approved a bill to establish a compulsory system, to be effective in 1950, which will insure all persons for certain medical benefits, without age, health, income, or occupational restrictions.[6] Under other proposed legislation, free hospital care will be available to the entire population.

Sweden's first national legislation to control and subsidize the operations of sickness funds was enacted in 1891. Subsequently, a basic Sickness Funds Order of 1931 (effective in part in 1935 and in part in 1938) required that, in addition to paying cash sickness benefits, approved funds should reimburse their members for medical expenses; called for registration of all funds with 50 or more members; and provided larger national subsidies. The voluntary system that has evolved through the years has been relatively limited in coverage and in scope of medical benefits. It should be considered, however, in relation to the extent to which rich and poor alike use tax-supported hospitals and other public health facilities. Through district and municipal physicians, nurses, dentists, and hospitals, medical care of sick persons—at a small charge if they are able to pay—is closely associated with general public health services.

Administration

The new compulsory health insurance program will use the administrative machinery of the existing voluntary system. At present, the Royal Pension Board in the Ministry of Social Affairs carries national responsibility for approval of sickness funds, supervision of their activities, and authorization of national subsidies; it also administers the compulsory old-age and invalidity pension program. The Royal Medical Board in the same Ministry is the central authority responsible for determining national standards and issuing regulations for medical benefits. Local governments, district and municipal, administer public medical services through salaried physicians, dentists, nurses, midwives, and hospital staffs. Many of the salaried doctors receive fees under the health insurance system for serving members of sickness funds.

Nearly all functions of health insurance administration are carried by local sickness funds (1,700 in 1946, 1,645 in 1943). Most of these funds are general or community funds, though some cover employees of individual factories or other occupational groups. As a rule, each rural area or small town has only one local fund, while large communities are divided into several districts, each with its own local fund. All local funds are attached to a central fund (29 in 1946, 28 in 1943), and all members of local funds must thus be indirect members of that central fund. Central funds pay cash sickness benefits to their indirect members after the exhaustion of rights to benefits in the local fund.

Coverage

The new compulsory system will waive all coverage restrictions for medical care, but only gainfully employed persons will be insured for cash sickness benefits. Under the existing voluntary system, persons must be in good health and aged 15–40 (in some funds, aged 15–50) when admitted to membership in a sickness fund, and an income restriction applied to coverage for medical benefits excludes persons whose annual assessment for national income and property tax exceeds 8,000 kronor (about $2,240).

[6] No information is yet available on the date of royal assent or statute number of the new health insurance law; data on the program are taken mainly from the Government's bill, introduced September 27, 1946 (45).

On December 31, 1943, a total of 2,147,381 men and women, or approximately 42 percent of the adult population of Sweden, held membership in approved sickness funds. All women members were covered for maternity benefits, and 2,025,000 members had insured their children under age 15 for medical benefits. The total adult membership at the end of 1943 was distributed as follows (*53*, p. 8):

Insurance carried	Total	Men	Women
Total	2,147,381	1,046,867	1,100,514
Medical benefits only	65,739	11,951	53,788
Cash sickness benefits only	115,439	83,420	32,019
Both types of benefit	1,966,203	951,496	1,014,707

All adults of working age are insured for old-age and invalidity pensions under the existing compulsory system.

Financing

Under the new compulsory system, insured persons will contribute about Kr. 24 a year toward cash sickness benefits and the medical benefits provided by sickness funds, and the contribution will also insure their dependents for medical benefits. Under the voluntary system, contributions have varied among funds; they have differed also with the amount of cash sickness benefit for which insurance is carried and have been increased slightly if the children of the insured person are to be eligible for medical benefits. In general, a person now pays about Kr. 58 a year if his daily cash benefit is Kr. 4 and if he and his children are covered for medical care.

No employer contributions are required under either the new or existing health insurance programs, though some employers now contribute to occupational funds on behalf of their employees.

Under the new law, the National Government will pay a membership subsidy of Kr. 3–6 a year (now a flat Kr. 3 a year) for each contributor; the medical subsidy will continue to represent about half the sickness fund's expenditures for medical benefits; and the subsidy toward cash sickness benefits will also be one-half the fund's expenditures (now it is Kr. 0.50 for each day of cash sickness benefits or hospitalization). In addition, the National Government will bear the entire costs of supplementary cash allowances for the wife and children of insured persons who are in receipt of cash sickness benefits, allowances which are not payable under the voluntary system. The maternity subsidy is now Kr. 75 per confinement for any member of a sickness fund who is eligible for maternity benefits. Some towns also grant subsidies to local sickness funds under the existing voluntary system, and local revenues meet a large share of the costs of hospitalization for insured as well as other persons. Under new proposals, national revenues will bear a large part of these costs for the entire population.

In 1943, the total income of the voluntary health insurance system was Kr. 95,078,000 from the following sources (*53*, p. 22):

Source	Amount, in kronor	Percent of total
Total	95,078,000	100.0
Contributions	58,684,000	61.7
National subsidy	26,628,000	28.0
Interest	1,822,000	1.9
Other	7,944,000	8.4

Total expenditures in the same year amounted to Kr. 81,038,000 (*53*, p. 22):

Type of expenditure	Amount, in kronor	Percent of total
Total	81,038,000	100.0
Cash sickness benefits	40,044,000	49.4
Reimbursement for medical care	19,814,000	24.5
Maternity benefits	8,037,000	9.9
Administration	9,980,000	12.3
Other	3,163,000	3.9

The newly enacted provisions for invalidity pensions will require a maximum contribution of Kr. 100 a year (now Kr. 20) from all persons aged 18–65. This contribution, which varies with income, goes toward old-age as well as invalidity pensions, which are, and will continue to be, largely financed from national and local tax revenues.

The new health insurance law will continue the practice of providing reimbursement for a part of insured persons' expenditures for the services of general practitioners, and, as now, patients will have free choice of the practitioners who are willing to accept them. Insured patients will pay their own fees and will be reimbursed by the sickness fund for three-fourths (now two-thirds) of the amount set for the service in a fee schedule. These fees are now increased for a home call, night call, and the physician's mileage, and higher rates are set for home and office calls in Stockholm than in other parts of the country.

Cash Benefits

Sickness.—Under the new law, nearly all gainful workers will be insured for a uniform amount of Kr. 3.50 a day, with supplements for the wives and children of insured men.[7] The waiting period will be 3 days and the benefit will be payable for as much as 730 days. At present, persons who insure for cash benefits receive, after a 3-day waiting period (which is sometimes increased to 7 days), a daily amount ranging from Kr. 1 to Kr. 6. The benefit is now payable for 18 days by some local funds and for 90 days by those whose reserves are adequate; thereafter, the central fund with which the local fund is affiliated pays the benefit up to a combined total of 2 or 3 years for any one illness. To be eligible, a member must show that a physician has ordered him to abstain from work, or that illness has reduced his working capacity by at least one-fourth.

Maternity.—No information is yet available on the legislative status of proposals to increase the cash maternity benefit and provide it, on a noncontributory basis, for all confinements. The lump sum proposed would be Kr. 200 (now Kr. 110); in addition, employed women would have a daily benefit of Kr. 2–7, depending on their income, payable for 180 days; other women would receive Kr. 1.50 a day for 90 days. Under existing provisions, sickness funds pay the lump-sum maternity benefit only to an employed woman who has been a member for at least 270 days before confinement.

Invalidity.—Under the new law for old-age and invalidity pensions, the basic invalidity pension will be Kr. 1,000 a year for a single person, with supplemental amounts based on need. At present the basic amount is Kr. 70, increased in proportion to contributions paid and the pensioner's need. It is payable to any person aged 16–66 whose working capacity is reduced by two-thirds or more.

[7] Amounts will be lower for adolescents and aged persons. All amounts may be increased through voluntary insurance.

Medical Benefits

The proposed health security system includes hospital services for the entire population without charge, free drugs and medicines obtained on prescriptions, and other medicines at half cost. Medical benefits under the compulsory health insurance program will include reimbursement for three-fourths of amounts set in fee schedules for general practitioners' services and X-ray examinations and treatment by specialists. With other provisions for a comprehensive program of dental care, authorized in 1939, and recently expanded provisions for maternal and child health, both outside the health insurance system, the proposed health services financed from public funds will encompass broad fields of health security for the entire population.

Medical benefits under the present system now vary among funds. They are available without duration limit (except for hospitalization) to insured persons who meet the eligibility requirements and to the young children of members who have contributed on their behalf. General practitioner services comprise consultations and visits at the physician's office or in the patient's home. Specialist care is provided as part of the hospital benefit, which includes ward care for as long as 2 years (3 years in some funds) for any one illness. A few funds include X-ray and physiotherapy services, and a few pay part of the costs of drugs and medicines.

DENMARK

The war and the nearly world-wide concern with measures to extend the scope of social insurance and health services have not greatly affected existing social security programs in Denmark or plans for the future. The reason lies, perhaps, in the breadth and integration of the programs established under the Social Reform Acts of 1933, as well as in the extent to which hospital and other medical services are available at minimal or no charge to nearly all the Danish population. Through liberal grants from national and local tax revenues and the mechanisms of social insurance and public assistance, virtually the entire population has long been protected against the fear of want in old age, invalidity, unemployment, and illness.

In its Sickness Fund Act of 1892, Denmark closely paralleled Sweden by establishing national standards and subsidies for voluntary sickness funds. Since 1921 the distinction between voluntary and compulsory membership in these funds has been virtually obliterated in Denmark. Nearly all persons of working age must pay contributions to the invalidity insurance system, and since these contributions are collected by the sickness funds of the health insurance system, membership in these funds is obligatory. Membership, however, may be passive (without rights to medical or cash benefits) or active (with such rights). Fines, larger in amount than the annual dues for passive membership, and loss of rights to a noncontributory old-age pension and contributory invalidity pension, as well as loss of franchise in the event of receipt of public assistance, serve as strong inducements to maintain membership in the voluntary health insurance system.

Administration

The Sickness Fund Directorate, in the Ministry of Social Affairs, approves local sickness funds, supervises their operations, determines their financial adequacy, authorizes their contracts with physicians and other practitioners, and pays them the amounts due as public subsidies. The Directorate also supervises 18 nonsubsidized sickness benefit societies which offer membership to persons whose resources temporarily or permanently exceed the maximum for active membership in local sickness funds. In the administration of the health insurance

program, the Directorate is assisted by a Sickness Fund Council composed of 12 representatives elected by committees of local sickness funds.

The National Invalidity Insurance Fund is also administered by the Sickness Fund Directorate, with the aid of an Invalidity Insurance Court that determines eligibility for invalidity pensions. All physicians must report to the Invalidity Court any condition among their patients under age 30 that might lead to considerable reduction of working capacity. That Court has authority to provide extensive measures for physical and vocational rehabilitation and financial aid to help start people in occupations suitable to their working capacity.

Local sickness funds, usually only one to a designated geographic area, are the local self-governing units for administering health insurance. Some funds are limited to certain occupational groups, but most are open to all residents of the area, and no one may belong to more than one fund. For Government approval, a fund must have at least 200 members; if the membership falls below that minimum, it must combine with another fund. On January 1, 1945, there were 1,591 approved and subsidized sickness funds. Active members of these funds elect their own officers and advisory committees and control the administration of medical and cash benefits, subject to the supervision of the National Directorate. In addition, the 18 nonsubsidized sickness benefit societies offer passive membership to all income groups and permit active membership (insurance for medical and cash benefits) for persons whose annual income bars them from active membership in the subsidized local sickness funds.

Coverage

Active or passive membership in an approved, subsidized local sickness fund or in one of the 18 nonsubsidized benefit societies is compulsory for all adults under age 60 who are potentially able to make some contribution to self support. When admitted to *active* membership in a subsidized fund, a person must be aged 14–40, must be in relatively good health, and must not have an annual income exceeding 5,800 kroner ($1,218) in Copenhagen, Kr. 5,400 in the provincial towns, and Kr. 4,400 in rural districts, with an additional Kr. 475 a year allowed for each dependent. The value of property owned is also taken into account. These restrictions bar only about 8 percent of the gainful workers of the country.

Active membership includes coverage for medical benefits for the members' children under age 15. Persons with active status in subsidized funds must transfer to passive membership when their property and income exceed the specified limits. Within certain age limits, persons with passive status may become active members when their financial resources decline.

On December 31, 1943, the health insurance system covered about 90 percent of the Danish population of 4,000,000. The membership was distributed as follows (*62*, pp. 9, 72; *66*, p. 38):

Type of membership	Total membership	Subsidized local funds	Nonsubsidized benefit societies
Total	3,716,862	3,471,262	245,600
Active members	3,473,801	3,230,630	243,171
Adults	2,565,320	2,380,630	184,690
Children under age 15	908,481	850,000	58,481
Passive members	243,061	240,632	2,429

Financing

Passive members pay Kr. 2.40 a year, plus an annual contribution of Kr. 7.20–9.60 toward invalidity pensions. Contributions of active members vary among

funds. They also differ with the amount of cash sickness and death benefit for which the person is insured. In Aarhus, for example, insurance for medical benefits for the member and his young children costs about Kr. 2.60–2.80 a month without cash sickness benefits, depending on whether the death benefit is the minimum of Kr. 100 or the maximum of Kr. 300. In addition, active members pay the same contributions toward invalidity pensions as do those with passive status.

Sickness funds collect the monthly contributions from their active members and affix stamps in the members' books to indicate that the contributions have been paid; the funds also collect the annual dues for passive membership and the annual premiums for invalidity insurance. The penalty for failure to pay contributions is Kr. 13 a year, and in certain circumstances may deprive persons of rights to regain active membership, or qualify for invalidity or old-age pensions. Employers do not contribute toward their employees' medical and cash sickness benefits but pay Kr. 6 a year toward invalidity pensions for those whom they employ for a full year.

The National Government pays each approved sickness fund a subsidy of Kr. 2 a year for each active member, plus one-fourth of the amount the fund expends for medical and cash benefits. In addition, the Government pays three-eighths of the fund's expenditures for medical and cash benefits to persons who have a chronic disability on admission. No subsidies or Government payments go to the 18 sickness benefit societies which insure persons in higher income groups.

The local government pays membership contributions for persons who are unable to pay their own dues and subsidies for those who are already disabled when they enter a sickness fund. They either defray the entire costs of hospital care or charge the sickness fund only half the rates nonmembers pay for ward care. In addition, national and local governments share in meeting the costs of invalidity pensions in excess of the amounts contributed.

In 1944, the income of subsidized sickness funds amounted to Kr. 127,321,268, derived as follows (*62*, p. 19):

Source	Amount, in kroner	Percent of total	Source	Amount, in kroner	Percent of total
Total	127,321,268	100.0	National subsidies	28,765,655	22.6
			Commune subsidies	3,680,128	2.9
Contributions:			Interest	1,454,395	1.1
Active members	82,824,320	65.1	"Control tickets" [1]	1,382,881	1.1
Passive members	674,677	.5	Other	8,539,212	6.7

[1] Special charges for calls at night or on Sundays or holidays.

Expenditures of subsidized sickness funds amounted to Kr. 123,932,602 in the same period, or Kr. 52.11 per active member (*62*, pp. 20–21):

Type of expenditure	Amount, in kroner	Percent of total	Type of expenditure	Amount, in kroner	Percent of total
Total	123,932,602	100.0	Appliances, spectacles, etc.	1,643,710	1.3
			Home nursing	1,737,665	1.4
General practitioner services	28,326,608	22.8	Cash sickness benefits	9,721,570	7.9
Specialist services	5,562,790	4.5	Cash maternity benefits	6,693,245	5.4
Hospitalization	20,308,612	16.4	Funeral benefits	5,496,890	4.4
Dentistry	6,233,301	5.0	Administration	13,280,513	10.7
Medicines	14,316,154	11.6	Other	10,612,044	8.6

During the same period, expenditures of the invalidity insurance system amounted to Kr. 52,148,961.

At the beginning of each fiscal year, active members of the sickness funds indi-

cate the physician of their choice. About one-third of the subsidized funds, which together have about two-thirds of the total membership, use the capitation method of remunerating physicians. The other funds, mainly those in rural areas, use a fee-for-service method. Under both methods, the physician may charge a small added fee for certifying illness and for night, Sunday, and holiday calls. The capitation amounts and fees for service are agreed on by sickness funds and practitioners, but to be valid must be approved by the Minister of Social Affairs. The sickness fund pays the physician quarterly. The capitation fee varies among funds and differs with the scope of services provided. For a general practitioner in Odense, for example, it is Kr. 9 a year for each insured person (with or without children) on his list, but is 50 percent higher for insured persons who have a chronic disease when admitted to membership.

Cash Benefits

Sickness.—After a qualifying period of 6 weeks, amounts varying from Kr. 0.40 to a maximum of Kr. 6 are payable daily to active fund members whose physicians certify their incapacity for work. Self-employed as well as employed persons may insure for cash benefits, but no one is permitted to insure for more than four-fifths of his customary earnings. Benefits are not payable for sickness of less than 4, or in some cases, 7 days' duration. For protracted illness, the duration of benefits can be as long as 364 days. If the fund member is still incapacitated at the end of a year, he or she may qualify for an invalidity pension.

Maternity.—Employed women who have been active members of a sickness fund for 10 months before confinement receive a cash maternity benefit equal in amount to the sickness benefit for which they are insured. The benefit is usually payable for only 14 days after confinement, but may be extended to as much as 4–6 weeks if the mother is nursing the child or needs longer maternity leave. It is also payable for 8 weeks before confinement, if a physician certifies that continuance at work would be detrimental to the mother's or child's health.

Invalidity.—An insured person who retains less than one-third of his earning capacity is eligible for a monthly pension of Kr. 70.50–175.25, depending on sex, marital status, and the area in which he lives. The basic pension is increased by a supplement for young children dependent on the pensioner, by an additional supplement if the pensioner is helpless or if he is blind or nearly blind, and by a personal supplement related to need. When the invalidity pensioner reaches age 60, his invalidity pension is replaced by an old-age pension of approximately the same amount.

Medical Benefits

For Government approval and subsidy, a sickness fund must guarantee an active member and his or her young children all necessary services of a general practitioner, free hospital treatment, and three-fourths of the member's expenditures for certain prescribed medicines such as insulin and liver preparations. Many funds provide additional benefits, such as services of specialists, dental care, care in convalescent homes, home nursing, and part of the costs of medicines and appliances. For an adult, 6 weeks' active membership is required for eligibility for medical benefits, but there is no qualifying period set for care of his or her young children or for any condition resulting from an accident. If a member receives medical benefits for as many as 420 days in 3 consecutive years, he is transferred to passive membership for at least 12 months. He can be reinstated as an active member thereafter only on medical certification that he is in good health.

As in Sweden, hospitalization includes the free services of surgeons, other specialists, and all other hospital personnel. Central hospitals are already in opera-

tion or planned in all but two of the counties of Denmark proper, providing special equipment and personnel for the care of medical conditions which cannot be effectively or economically diagnosed or treated in the smaller hospitals of the country. Plans for more extensive public health and welfare programs are also under way.

THE NETHERLANDS

When the Netherlands was invaded in 1940, social security programs were in operation for workmen's compensation, old age, invalidity and survivors' pensions, cash benefits for maternity, and funeral benefits. A Children's Allowance Act had been passed in 1939, but not yet put into effect. These programs, varying in comprehensiveness and lacking in coordination, were financed, with few exceptions, by contributions of employers and employees. Mutual benefit societies, approved industrial associations composed of employees' and employers' representatives, and Government-controlled labor boards were authorized to carry out the provisions of the various insurance laws.

Before the war, plans had been made by the Dutch Government to revise the Netherlands' social insurance systems. These plans, directed toward improving administrative coordination, increasing benefits, and extending coverage, were temporarily interrupted by the German invasion. The occupation authorities, however, issued a decree in 1941, establishing a compulsory system of medical care insurance, based on plans that had been worked out by the prewar Dutch Government. Though sponsored by the Germans, this system eventually won favor among the Dutch and was retained after their liberation; it is still in effect and is being used as a basis for further extension of health insurance.

Since the end of World War II, the Dutch Government has again been considering plans for a more comprehensive and administratively simpler social security system. Prepared in 1943 by the Government-in-Exile, these plans propose greater financial participation by the National Government in the provision of social security benefits.

Administration

Compulsory health insurance in the Netherlands is administered under two statutes: the Sickness Law of 1929, providing cash benefits for wage losses during illness; and the Sickness Funds Decree of 1941, providing medical benefits. The cash-benefit system is administered by the Social Insurance Section of the Ministry of Social Affairs and the medical-benefits system by a director responsible to the Minister.

Locally, the Sickness Law of 1929 is administered largely by 24 regional labor boards and by approved industrial associations. The labor boards, public bodies made up of employer and employee representatives, are charged with administration of many of the social insurance programs, including invalidity and old-age pensions and children's allowances. The activities of the labor boards are supervised by the National Insurance Bank. This bank, governed by an 11-man council appointed by the Minister of Social Affairs, holds the funds contributed toward social insurance programs and is authorized to make regulations concerning them.

Approved industrial associations—nonprofit organizations established jointly by central bodies of employers and workers—also administer cash sickness benefits under the compulsory program. Employers may insure their employees for cash benefits either with the Government-controlled labor boards or with private industrial associations. If an employer does not insure for cash benefits with the associations, his employees are automatically covered in this respect by the labor

boards. A large majority of employers in the Netherlands are insured with the industrial associations. By-laws of the associations must be approved by the Minister of Social Affairs.

The insurance work of the labor boards is coordinated by an Association of Labor Boards, and most of the industrial associations belong to a Federation of Industrial Associations, which is authorized to administer the cash-benefit system for its component associations. The Federation, in turn, is affiliated with a private agency called Centraal Beheer (Central Management); in addition, this agency serves mutual benefit societies and commercial insurance companies offering various kinds of voluntary insurance benefits. Centraal Beheer does not insure any risks itself, but merely administers the insurance systems of many of its member organizations. It collects contributions, pays cash benefits, and organizes medical control for some of the industrial associations belonging to it by virtue of their membership in the Federation.

The Sickness Decree of 1941, establishing compulsory medical care insurance, is administered by special funds, called general sickness funds. At the time the decree was promulgated, there were in the Netherlands more than 650 mutual benefit societies of various types, providing voluntary insurance for medical care. Some of them were approved by the Government, under the decree, as "General Sickness Funds" and authorized to administer the compulsory program for medical benefits; on April 1, 1946, there were 170 such funds. Lump-sum funeral grants, provided for by the 1941 Decree, are also administered by the general sickness funds. These funds must submit their by-laws to the Minister of Social Affairs for approval.

Coverage

In general, all persons subject to the Sickness Law of 1929 are also compulsorily insured for medical care under the Sickness Funds Decree of 1941. Covered by both statutes are employees under age 65 who earn not more than 3,000 gulden (about $1,140) a year.[8] Contributions toward medical benefits cover, in addition to the insured person himself, his dependent spouse, his children under age 16, and, under certain conditions, his dependent parents and his spouse's parents.

Self-employed persons are not required to carry health insurance, but may insure themselves on a voluntary basis for medical care with one of the general sickness funds and for cash benefits with the labor boards, provided their annual income, if they live in cities, does not exceed G. 3,000. The income limit for this type of voluntary insurance varies from G. 2,000 to G. 2,500 for self-employed persons living in rural areas. Compulsory and voluntary insurance accounts maintained by the same sickness fund must be administered separately.

Approximately 3,500,000 persons were included under both types of compulsory health insurance on December 3, 1945, and another 2,550,000 were voluntarily insured. The total number of insured persons represents about two-thirds of the Dutch population.

Among the groups excluded from coverage for both types of compulsory health insurance are casual workers; seamen on vessels which sail outside Dutch coastal waters; members of the armed forces; those suffering from occupational diseases (covered under the Accidents Law for compensation); all permanent Government employees; apprentices who do not receive cash wages; and those who earn less than G. 0.40 a day. Some of these groups, such as seamen and Government employees, are covered by separate programs.

[8] A bill has recently been introduced in Parliament to raise the income limit for the compulsory insurance system for cash sickness benefits to G. 3,750 a year.

Invalidity insurance applies, in general, to employees whose annual income does not exceed G. 3,000. In 1943, approximately 4,000,000 people were insured under the compulsory invalidity insurance program.

Financing

Contributions for medical care and cash benefits under the compulsory system normally amount, together, to 7 percent of total wages; 3 percent (2 percent paid by the employer, 1 percent by the employee) goes to finance cash benefits and 4 percent (2 percent each paid by the employer and employee) to finance medical benefits. Both sets of contributions are paid by the employer, who deducts the employee's share from his wages.

The contributions, collected periodically by the labor board sickness funds for cash sickness benefits, are deposited with the National Insurance Bank, and the boards draw on the central fund for payment of benefits. The industrial associations retain contributions collected for cash benefit payments.

A separate reinsurance or equalization fund is set up in the bank to meet the cost of medical benefits. The labor boards and industrial associations collect premiums from the employers every 6 months and deposit the receipts with the equalization fund, which then allots a prorated share of the total contribution to each general sickness fund to cover the cost of medical benefits to its members. A record is kept of the employees' share of the contribution for medical benefits by means of special coupons, purchased by the employers from the Government, and given to insured employees as receipts whenever a contribution is made on their behalf to the general sickness funds.

Premiums paid by voluntarily insured persons for either cash or medical benefits are fixed by the various insurance funds for each individual when he joins the system. Persons who are voluntarily insured for medical care pay their contributions directly to the general sickness fund with which they affiliate. For hazardous industries, such as mining, compulsory contributions for cash benefits are higher than in less dangerous types of work. The increased contribution in such cases must be paid entirely by the employer.

The maximum contribution for invalidity insurance is G. 0.60 per insured person per week, which is paid entirely by the employer. Recently, the National Treasury has also been contributing to the payment of invalidity benefits. Neither the cash sickness nor medical benefit systems, however, receive financial aid from the Government.

Costs of medical care for the 3,317,420 persons compulsorily insured for 1943 (latest available data), based on information received from 157 general sickness funds, have been officially estimated as follows (*71*, p. 9):

Type of expenditure	Amount, in gulden	Percent of total	Cost per insured, in gulden	Type of expenditure	Amount, in gulden	Percent of total	Cost per insured, in gulden
Total	50,100,000	100.0	15.14	Dental care	3,700,000	7.4	1.11
				Obstetrical care	1,100,000	2.2	.33
General medical care	10,500,000	20.9	3.18	Hospital care	11,800,000	23.5	3.56
Medication	9,300,000	18.6	2.82	Administration	5,800,000	11.6	1.74
Specialist care	4,800,000	9.6	1.44	Other benefits	3,100,000	6.2	.96

Total cash benefits for sickness paid in 1942 were G. 43,215,000, at an administrative cost of G. 6,397,000; total contributions for cash benefits for the same period were G. 49,100,000.

Persons insured for medical benefits have free choice of doctor, and may change

every half year; they may also choose their own pharmacist. No more than 3,000 persons, including dependents of insured persons, are permitted on the insurance doctor's panel.

General practitioners are paid by the capitation system, receiving an average remuneration in cities of G. 3.50 per year per individual on their panel from the general sickness funds; a general practitioner with his own dispensary is paid G. 5.20 as a capitation fee. The funds pay specialists, in general, on a fee-for-service basis. These fees vary greatly throughout the country, in accordance with fee schedules which are drawn up by individual funds and doctors, and are comparatively uniform only in large cities.

The funds pay the municipal authorities, in large cities, a certain amount per insured person per year for hospital care; the individual hospitals are then paid by the municipality for care of insured patients. In rural areas, direct payment is usually made to hospitals by the funds.

Many of the general sickness funds operate dental clinics, paying dentists at the rate of G. 5.75 per hour.

Cash Benefits

Sickness.—Cash benefits for illness are payable to an insured person for a maximum of 26 weeks, starting on the third day after the onset of the illness. The allowance, paid for each day during this period except Sunday, usually amounts to 80 percent of the average daily wage earned during the preceding 13 weeks, although, in certain cases, the Government may approve payment of a benefit equal to 90 percent of the average wage. The maximum daily wage on the basis of which the cash benefit may be calculated is G. 8. In certain circumstances, the 3-day waiting period may be reduced and the duration of benefits extended to 12 months. If an insured person receives cash payments for the same illness for a total of 156 days in a 12-month period, he may not receive cash benefits for more than 78 days for that ailment during the following year. Certification of incapacity for cash-benefit purposes is not done by attending doctors, but by special control doctors.

Maternity.—A lump-sum grant of G. 55 is given for maternity whether the woman is insured in her own right or is the dependent of an insured man. This grant is made, however, only if a midwife attends the delivery. The midwife's fee and that of the obstetrical housekeeper-aide are usually met out of this sum. For 6 weeks before and after confinement, an employed woman receives, in addition, cash benefits equal to her full salary, up to a maximum of G. 8 per day. The postnatal payment may be extended to 6 months if childbirth causes incapacity for that length of time.

Invalidity.—When the income of an employed person compulsorily insured for invalidity benefits drops to one-third of normal because of disability, he receives a weekly cash benefit, provided his employer has made 150 weekly contributions on his behalf. The amount of the pension is directly related to the number and amount of contributions made by the employer. Temporary invalidity benefits may be received after 6 months of illness, and permanent benefits whenever the fact of permanent invalidity is established thereafter. Those compulsorily insured for invalidity must register individually with the labor boards. Before the war, the maximum pension was G. 6 a week, but it has now been increased by a grant from the National Treasury to include allowances for dependent children of the insured person.

Medical Benefits

Medical benefits for compulsorily insured individuals and their dependents include general practitioner care; surgical, obstetrical, and other specialist

treatment; hospitalization for 42 days; all necessary medical and surgical appliances; some dental treatment; ambulance service; and part of the cost of care in a tuberculosis sanitarium. Dental work for which the sickness funds pay in full includes extractions, surgery, and cleaning. Dentures are paid for in part by the funds; crowns and bridges must be paid for by the insured person himself.

In maternity cases, an insured woman or the dependent of an insured man is covered for all necessary obstetrical care. Usually, this is accomplished by the G. 55 cash grant provided for payment of the midwife and obstetrical housekeeper-aide. Specialist care during confinement is furnished by some sickness funds, but usually only if the midwife considers it necessary.

Although all drugs are free to those insured for medical benefits, doctors are often limited in the total cost of drugs they may prescribe. Some funds specify that a physician must pay for any drugs he prescribes above a limit set in terms of the average cost of drugs prescribed by the other doctors of the fund.

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DEATHS DURING WEEK ENDED FEB. 15, 1947

[From the Weekly Mortality Index, issued by the National Office of Vital Statistics]

	Week ended Feb. 15, 1947	Corresponding week, 1946
Data for 93 large cities of the United States:		
Total deaths	10,007	10,063
Median for 3 prior years	9,913	
Total deaths, first 7 weeks of year	70,037	74,530
Deaths under 1 year of age	826	631
Median for 3 prior years	642	
Deaths under 1 year of age, first 7 weeks of year	5,796	4,260
Data from industrial insurance companies:		
Policies in force	67,302,666	67,161,803
Number of death claims	10,354	12,368
Death claims per 1,000 policies in force, annual rate	8.0	9.6
Death claims per 1,000 policies, first 7 weeks of year, annual rate	9.6	11.4

INCIDENCE OF DISEASE

No health department, State or local, can effectively prevent or control disease without knowledge of when, where, and under what conditions cases are occurring

UNITED STATES

REPORTS FROM STATES FOR WEEK ENDED FEBRUARY 22, 1947

Summary

A total of 5,192 cases of influenza was reported, as compared with 3,459 last week and a 5-year (1942–46) median of 5,984. Increases occurred in the South Central, West North Central, Mountain, and Pacific areas. Of the current total, 4,689 cases, or approximately 90 percent, were reported in 7 States, as follows (last week's figures in parentheses: Texas 2,465 (1,761), Colorado 1,117 (140), Virginia 534 (490), South Carolina 225 (426), Arkansas 126 (69), Arizona 120 (64), Alabama 102 (43). No other State reported more than 74 cases. The total for the year to date is 32,617, as compared with 155,013 for the same period last year, and a 5-year median of 39,064.

Of 37 cases of poliomyelitis reported for the current week (as compared with 43 last week, 40 for the corresponding week last year, and a 5-year median of 26), California reported 9, Virginia 4, and Michigan and North Dakota 3 each. The total to date is 500, as compared with 353 for the corresponding period last year and a 5-year median of 228.

A total of 277 cases of diphtheria was reported, as compared with 288 last week, 337 for the corresponding week last year, and a 5-year median of 261. The cumulative total to date is 2,443, as compared with 3,211 for the corresponding period last year and a 5-year median of 2,627.

The total of 79 cases of meningococcus meningitis reported (last week 72, 5-year median 290) is below the figure for any corresponding week of the past 5 years. To date, 667 cases have been reported, as compared with a 5-year median of 1,987. The corresponding figure for last year is 1,643, the lowest number for the corresponding 8 weeks of any of the past 4 years.

Of the week's total of 114 cases undulant fever (last week 95, total to date 748, same period last year 503), 71 occurred in the North Central area and 20 in Texas.

Deaths recorded for the week in 93 large cities in the United States totaled 9,741, as compared with 10,007 last week, 9,474 and 9,351, respectively, for the corresponding weeks of 1946 and 1945, and a 3-year (1944–46) median of 9,474. The cumulative total is 79,778, as compared with 84,004 for the corresponding period last year.

Telegraphic morbidity reports from State health officers for the week ended Feb. 22, 1947, and comparison with corresponding week of 1946 and 5-year median

In these tables a zero indicates a definite report, while leaders imply that, although none was reported, cases may have occurred.

Division and State	Diphtheria			Influenza			Measles			Meningitis, meningococcus		
	Week ended—		Median 1942–46	Week ended—		Median 1942–46	Week ended—		Median 1942–46	Week ended—		Median 1942–46
	Feb. 22, 1947	Feb. 23, 1946		Feb. 22, 1947	Feb. 23, 1946		Feb. 22, 1947	Feb. 23, 1946		Feb. 22, 1947	Feb. 23, 1946	
NEW ENGLAND												
Maine	1	0	0	1	2	2	301	2	15	0	0	1
New Hampshire	0	0	0	1	----	----	7	----	8	0	1	1
Vermont	0	1	0	----	----	----	248	1	14	0	0	0
Massachusetts	13	3	2	----	----	----	461	260	411	3	4	5
Rhode Island	2	0	0	1	1	1	211	4	34	0	1	1
Connecticut	0	0	0	----	9	3	382	68	238	0	2	4
MIDDLE ATLANTIC												
New York	20	19	19	[1] 7	[1] 14	[1] 10	243	1,469	1,469	7	21	27
New Jersey	5	1	2	3	13	13	287	689	689	3	5	6
Pennsylvania	15	13	13	----	6	6	513	1,614	1,614	8	14	25
EAST NORTH CENTRAL												
Ohio	13	22	10	5	21	21	641	239	217	2	4	6
Indiana	10	12	6	8	29	21	41	448	298	0	4	4
Illinois	5	10	13	1	8	12	56	1,483	553	4	15	15
Michigan [2]	5	26	5	2	5	5	72	2,103	285	4	7	12
Wisconsin	0	2	2	20	63	63	196	386	510	1	1	2
WEST NORTH CENTRAL												
Minnesota	8	6	5	----	2	2	114	22	42	4	1	1
Iowa	1	7	4	----	----	2	22	33	276	3	5	3
Missouri	1	6	6	10	6	4	4	360	382	1	7	7
North Dakota	3	0	0	21	6	6	4	----	42	0	2	1
South Dakota	0	0	2	----	----	----	11	133	85	0	1	1
Nebraska	0	1	3	1	4	10	7	70	70	0	0	1
Kansas	7	6	5	61	27	8	9	939	343	2	1	2
SOUTH ATLANTIC												
Delaware	2	0	1	----	----	----	1	6	9	0	0	1
Maryland [2]	8	14	4	6	16	16	38	172	172	2	5	8
District of Columbia	1	1	0	----	----	2	11	41	44	0	0	2
Virginia	4	6	6	534	743	746	267	349	349	2	5	12
West Virginia	1	1	4	52	8	39	89	22	58	1	0	4
North Carolina	8	14	10	----	----	36	209	237	237	2	1	7
South Carolina	0	11	4	225	923	923	33	170	170	1	2	2
Georgia	3	5	5	39	113	113	96	144	144	1	4	3
Florida	6	2	2	18	4	4	11	90	90	0	6	9
EAST SOUTH CENTRAL												
Kentucky	12	9	6	8	10	11	2	426	142	0	3	8
Tennessee	5	4	3	20	91	68	54	186	226	2	7	8
Alabama	11	11	9	102	542	389	40	159	159	2	6	6
Mississippi [2]	4	5	5	----	----	----	----	----	----	0	6	6
WEST SOUTH CENTRAL												
Arkansas	4	11	6	126	259	223	79	66	122	1	3	4
Louisiana	10	7	6	21	594	12	7	97	97	4	1	2
Oklahoma	5	1	6	59	127	129	1	154	105	0	1	1
Texas	29	37	36	2,465	3,030	1,951	152	518	697	8	10	16
MOUNTAIN												
Montana	2	6	2	11	3	11	279	11	125	0	0	1
Idaho	1	0	1	8	44	----	7	45	34	0	0	0
Wyoming	0	0	0	12	1	9	16	35	65	1	0	0
Colorado	3	6	6	1,117	61	61	51	132	228	0	2	3
New Mexico	2	3	2	2	2	2	48	14	28	0	0	1
Arizona	3	12	3	120	154	154	55	39	39	0	0	2
Utah [2]	0	0	0	16	45	45	2	289	111	0	0	0
Nevada	0	0	0	----	----	----	----	----	1	0	0	0
PACIFIC												
Washington	5	5	3	13	----	1	18	469	150	2	1	4
Oregon	10	6	2	2	20	21	23	169	132	0	1	1
California	29	25	25	74	228	126	148	1,362	752	8	15	25
Total	277	337	261	5,192	7,234	5,984	5,567	15,725	16,918	79	175	290
8 weeks	2,443	3,211	2,627	32,617	155,013	39,064	35,437	69,199	96,436	667	1,643	1,987
Seasonal low week [3]	(27th) July 5–11			(30th) July 26–Aug. 1			(35th) Aug. 30–Sept. 5			(37th) Sept. 13–19		
Total since low	10,009	14,855	11,552	65,592	517,261	74,926	58,324	95,323	134,449	1,639	3,147	4,149

[1] New York City only.
[2] Period ended earlier than Saturday.
[3] Dates between which the approximate low week ends. The specific date will vary from year to year.

Telegraphic morbidity reports from State health officers for the week ended Feb. 22, 1947, and comparison with corresponding week of 1946 and 5-year median—Con.

Division and State	Poliomyelitis			Scarlet fever			Smallpox			Typhoid and paratyphoid fever [4]		
	Week ended—		Median 1942–46	Week ended—		Median 1942–46	Week ended—		Median 1942–46	Week ended—		Median 1942–46
	Feb. 22, 1947	Feb. 23, 1946		Feb. 22, 1947	Feb. 23, 1946		Feb. 22, 1947	Feb. 23, 1946		Feb. 22, 1947	Feb. 23, 1946	
NEW ENGLAND												
Maine	0	0	0	20	23	23	0	0	0	0	0	0
New Hampshire	0	0	0	1	2	13	0	0	0	0	0	0
Vermont	0	0	0	10	13	14	0	0	0	0	0	0
Massachusetts	0	1	0	152	153	318	0	0	0	2	3	1
Rhode Island	0	0	0	13	0	17	0	0	0	0	0	0
Connecticut	0	1	0	60	39	79	0	0	0	1	1	1
MIDDLE ATLANTIC												
New York	1	3	1	359	451	486	0	0	0	0	0	4
New Jersey	0	0	1	156	108	134	0	1	0	2	2	1
Pennsylvania	0	1	1	200	319	535	0	0	0	2	1	3
EAST NORTH CENTRAL												
Ohio	0	2	1	406	373	373	0	0	0	0	0	3
Indiana	0	0	0	136	113	164	0	0	1	2	3	3
Illinois	2	0	0	134	210	327	0	0	1	2	0	1
Michigan [5]	3	1	1	197	142	241	0	0	0	1	1	1
Wisconsin	0	1	0	94	141	229	0	0	1	1	0	0
WEST NORTH CENTRAL												
Minnesota	2	0	0	50	60	101	0	0	0	0	0	0
Iowa	0	0	0	39	59	72	0	1	1	0	0	0
Missouri	0	1	0	40	75	133	0	0	0	0	3	1
North Dakota	3	0	0	14	1	30	0	0	0	0	0	0
South Dakota	0	0	0	22	18	18	0	0	0	2	0	0
Nebraska	0	1	0	40	34	82	0	0	0	0	0	0
Kansas	1	0	0	54	99	117	0	1	0	2	0	0
SOUTH ATLANTIC												
Delaware	0	0	0	11	7	7	0	0	0	0	1	0
Maryland [5]	0	1	0	24	81	102	0	0	0	1	0	0
District of Columbia	0	0	0	11	26	35	0	0	0	0	0	0
Virginia	4	0	0	45	61	61	0	0	0	3	2	2
West Virginia	0	0	0	10	37	43	0	0	0	0	0	2
North Carolina	1	1	0	22	46	44	0	0	0	0	0	0
South Carolina	1	0	0	11	11	7	0	0	0	0	0	1
Georgia	0	4	0	23	10	20	0	1	0	2	3	3
Florida	2	5	1	16	8	15	0	0	0	3	0	0
EAST SOUTH CENTRAL												
Kentucky	0	0	0	42	29	73	1	0	0	5	0	0
Tennessee	1	2	0	27	24	85	0	0	0	1	1	3
Alabama	1	1	1	20	9	18	1	0	0	1	2	1
Mississippi [5]	1	4	1	9	10	11	0	0	0	0	0	1
WEST SOUTH CENTRAL												
Arkansas	1	1	0	5	11	9	0	1	1	0	0	0
Louisiana	0	1	1	2	13	12	0	0	0	3	2	2
Oklahoma	2	1	1	10	21	32	0	0	0	0	2	2
Texas	1	1	1	38	78	78	1	2	1	1	6	5
MOUNTAIN												
Montana	0	0	0	6	1	22	0	0	0	1	1	0
Idaho	0	0	0	15	2	3	0	0	0	0	0	0
Wyoming	0	0	0	6	5	11	0	0	0	0	0	0
Colorado	0	1	0	53	34	63	0	0	0	0	2	0
New Mexico	0	0	0	10	24	10	0	0	0	0	0	0
Arizona	0	0	0	7	8	12	0	0	0	0	0	0
Utah [5]	1	0	0	11	41	51	0	0	0	0	0	0
Nevada	0	0	0	2	0	0	0	0	0	0	0	0
PACIFIC												
Washington	0	2	0	42	19	62	0	0	0	0	0	0
Oregon	0	0	0	47	21	21	0	0	0	3	1	1
California	9	3	3	146	218	218	0	1	0	0	2	2
Total	37	40	26	2,868	3,288	4,367	3	8	13	41	39	53
8 weeks	[5] 500	353	228	20,705	24,382	30,415	30	58	113	333	320	478
Seasonal low week [3]	(11th) Mar. 15–21			(32nd) Aug. 9–15			(35th) Aug. 30–Sept. 5			(11th) Mar. 15–21		
Total since low	[5] 25,275	13,690	12,308	47,391	62,953	69,361	84	134	230	3,861	4,571	5,612

[2] Period ended earlier than Saturday.
[3] Dates between which the approximate low week ends. The specific date will vary from year to year.
[4] Including paratyphoid fever reported separately, as follows: Massachusetts 2 (salmonella infection); New Jersey 1; South Dakota 2; Maryland 1; Virginia 1; Georgia 1; Kentucky 1; Oregon 1.
[5] Delayed report: Poliomyelitis, Arkansas, week ended February 8, 1 case, included in cumulative totals.

Telegraphic morbidity reports from State health officers for the week ended Feb. 22, 1947, and comparison with corresponding week of 1946 and 5-year median—Con.

Division and State	Whooping cough			Week ended Feb. 22, 1947							
	Week ended—		Median 1942–46	Dysentery			Encephalitis, infectious	Rocky Mt. spotted fever	Tularemia	Typhus fever, endemic	Undulant fever
	Feb. 22, 1947	Feb. 23, 1946		Amebic	Bacillary	Unspecified					
NEW ENGLAND											
Maine	18	23	32								
New Hampshire		1	1								
Vermont	15	14	23								3
Massachusetts	154	81	125		4		1				
Rhode Island	10	22	22								
Connecticut	40	58	58								3
MIDDLE ATLANTIC											
New York	155	177	177	9	2						3
New Jersey	186	108	115				1				1
Pennsylvania	238	123	171						1		
EAST NORTH CENTRAL											
Ohio	126	84	177								5
Indiana	68	10	26						2		2
Illinois	66	97	97				1		1		6
Michigan [2]	236	132	132		1						12
Wisconsin	180	62	103								14
WEST NORTH CENTRAL											
Minnesota	10	12	34	3							6
Iowa	48	4	12								20
Missouri	31	4	16								
North Dakota			4								
South Dakota	1		2			10					4
Nebraska	22	4	12								
Kansas	15	17	39				1	1	2		2
SOUTH ATLANTIC											
Delaware	5	5	1								
Maryland [2]	92	24	40	1						1	1
District of Columbia	9	5	6								
Virginia	111	43	54			47			1	1	
West Virginia	10	5	39								
North Carolina	32	56	123						2	1	
South Carolina	14	31	47	2	1				2		
Georgia	12	4	11		2				5	12	1
Florida	24	20	20						2	7	1
EAST SOUTH CENTRAL											
Kentucky	20	23	41						3	2	
Tennessee	20	12	40	1					2	1	
Alabama	31	13	25							3	3
Mississippi [2]									2	1	1
WEST SOUTH CENTRAL											
Arkansas	16	9	9	1	1	1			1		
Louisiana		4	2	3	1				2	4	
Oklahoma	24	1	13					1	1		
Texas	410	108	124	7	279	59			1	10	20
MOUNTAIN											
Montana	1	4	12						1		
Idaho	10	7									
Wyoming	12		2						1		
Colorado	44	31	30		1						1
New Mexico	34	6	9	1							
Arizona	14	14	29			25					1
Utah [2]	4	12	19								1
Nevada		3	1								
PACIFIC											
Washington	33	33	24	1		4					2
Oregon	12	15	18	3							
California	118	71	233	1	1		1			1	1
Total	2,731	1,582	2,406	33	293	146	5	2	32	44	114
Same week, 1946	1,582			49	189	82	7	0	20	52	52
Median, 1942–46	2,406			30	195	59	9	1	16	37	[4] 61
8 weeks: 1947	19,769			360	2,983	1,625	52	4	366	385	748
1946	14,396			322	2,428	955	61	3	175	438	503
Median, 1942–46	18,423			182	1,733	488	61	3	175	436	[4] 589

[2] Period ended earlier than Saturday.

[4] 2-year average, 1945–46.

Anthrax: Massachusetts 1 case; New Jersey 1 case; Pennsylvania 1 case.

NOTIFIABLE DISEASES, YEAR 1946

The figures in the following table are the totals of the monthly morbidity reports received from the State health authorities for the year 1946. These reports are preliminary and the figures are therefore more or less incomplete and subject to correction by final reports. In most instances they include cases reported in both civilian and military populations. The comparisons made are with similar preliminary reports; but, owing to population shifts and the presence of large military populations in many States since the 1940 census, the figures for some States may not be comparable with those for prior years, especially for certain diseases. Each State health officer has been requested to include in the monthly report for his State all diseases that are required by law or regulation to be reported in the State, although some do not do so. The lists of diseases required to be reported are not the same for each State. Only 11 of the common communicable diseases are notifiable in all the States. In some instances cases are reported, in some States, of diseases that are not required by law or regulation to be reported and the figures are included although manifestly incomplete. There are also variations among the States in the degree of, and checks on, the completeness of reporting of cases of the notifiable diseases; therefore comparisons as between States may not be justified for certain diseases. As compared with the deaths, incomplete case reports are obvious for such diseases as malaria, pellagra, pneumonia, and tuberculosis, while in many States other diseases, such as puerperal septicemia, rheumatic fever, and Vincent's infection, are not reportable.

In spite of these known deficiences, however, these monthly reports, which are published quarterly and annually in consolidated form, have proved of value in presenting early information regarding the reported incidence of a large group of diseases and in indicating trends by providing a comparison with similar preliminary figures for prior years. The table gives a general picture of the geographic prevalence of certain diseases, as the States are arranged by geographic areas.

Leaders are used in the table to indicate that no case of the disease was reported.

Consolidated monthly State morbidity reports for the year 1946

Division and State	Anthrax	Chickenpox	Conjunctivitis [1]	Diphtheria*	Dysentery, amebic	Dysentery, bacillary	Dysentery, undefined	Encephalitis, infectious	German measles	Hookworm disease	Influenza	Malaria [2]	Measles*	Meningitis, meningococcus*	Mumps	Ophthalmia neonatorum	Pellagra*	Pneumonia, all forms
NEW ENGLAND																		
Maine		2,303		144	4		1		916		186	88	4,868	36	3,761			744
New Hampshire		479		5	1				471		70	17	2,484	22	613			94
Vermont		1,990		32					1,640		314		3,070	7	2,191			157
Massachusetts	2	11,561	236	452	4	68		8	4,617	2		497	38,416	121	5,811	122		[3] 1,484
Rhode Island		618		32	2	11		1	37		46	[4] 203	1,318	38	421			313
Connecticut	1	5,269	70	72	29	14		6	2,462	6	825	456	7,918	89	8,928	1		2,727
MIDDLE ATLANTIC																		
New York	11	20,818		830	283	455		52	[5] 3,377	[5] 122	[5] 394	2,061	87,065	546	[5] 5,844	70		15,195
New Jersey	3	16,552		250	38	17	43	8	10,197		412	932	56,508	180	9,192	18		4,186
Pennsylvania	13	18,365		752	12	11		20		1	182	[6] 1	55,927	421	13,230	17		3,522
EAST NORTH CENTRAL																		
Ohio	1	11,543	2	912	98	9	8	9	2,120		515	414	16,121	264	6,716	530	1	2,740
Indiana		3,118	15	485	24	5	6	39	216	6	902	344	11,942	101	1,008	1		318
Illinois		11,728		474	199	38		57	1,364		333	[4] 562	25,995	366	5,286	421		6,149
Michigan		14,137	136	387	43	84	1	4	3,267	2	132	[4] 1,306	42,264	185	9,470	18		2,280
Wisconsin		18,612		158	13			7	6,198		2,616	69	46,465	104	17,071	7		[3] 649
WEST NORTH CENTRAL																		

Illinois		11,728		474	199	38		57	1,364		[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		[illegible]
Michigan		14,137	136	387	43	84	1	4	3,267	2	132	[4] 1,306	42,264	185	9,470	18		2,280
Wisconsin		18,612		158	13			7	6,198		2,616	69	46,465	104	17,071	7		[3] 649
WEST NORTH CENTRAL																		
Minnesota		2,113	1	754	[7] 109	4	8	3		[7] 12	79	999	1,335	118				218
Iowa		1,895		180	31	1		10	120		62	280	4,288	94	1,424			2,291
Missouri		1,007	3	272			25	8	150		221	354	6,547	147	1,051	1		1,087
North Dakota		290	3	87	5	5	7	16			344	5	236	20				681
South Dakota		415	1	70			4				[8] 164	18	1,061	15	276			36
Nebraska	2	1,291		84	6		2	17			1,151	157	5,624	29	498			144
Kansas		2,829	137	366	12		1	19	486	2	2,703	61	12,886	51	2,842		1	712
SOUTH ATLANTIC																		
Delaware		255		18			2					12	624	17	62			12
Maryland		3,181	10	546	9	21	8	6	989		210	73	11,503	96	778	27	1	1,721
District of Columbia		639		16		11					41	27	4,516	55	367		2	992
Virginia		2,759		548	7		2,716				24,875	498	13,390	203	1,730		31	3,018
West Virginia		955		212	44	1	26	1			4,679	88	2,673	83	1,048			293
North Carolina				590	19	8		3				369	9,011	120				
South Carolina		1,531		249	70	701		1	678	924	22,829	5,933	7,579	24	1,147	23	707	4,226
Georgia		652	32	341	37	119	29	2		4,928	1,930	583	4,142	46	413		25	809
Florida		971	87	450	80	14	29	15	163	3,742	592	500	3,120	94	1,561	18	13	755
EAST SOUTH CENTRAL																		
Kentucky		1,216		566	2	84		12	141	7	3,214	329	7,554	145	747		8	1,021
Tennessee		1,090	5	358	27	29	15	26	370	13	2,931	388	4,877	152	315	6	51	2,362
Alabama		854		370	25			19	1,134		11,260	1,541	3,992	129	888		33	3,582
Mississippi		6,541		441	1,395	7,160				4,951	63,677	17,387	19,322	99	5,384	32	2,065	16,506
WEST SOUTH CENTRAL																		
Arkansas		998		345	101	54	1	10	787	2	6,059	1,340	3,281	96	1,231	2	21	1,149
Louisiana		394		326	194	39		5	213	495	20,108	745	3,423	112	530	14	6	2,689
Oklahoma		629		209	46	14	12	13	14	21	6,578	512	4,556	67	452	1	23	998
Texas	1	11,184		1,544	851	14,742	1,919	33			79,259	6,799	31,465	312	12,684	105	893	9,838
MOUNTAIN																		
Montana		1,485	46	58	3		3	2	541		931	10	2,130	18	1,346			398
Idaho	1	912	66	54	4		34	4	655		1,877	66	2,184	12	490			387
Wyoming		538	22	45	7			2	101		84	49	1,075	8	213			123
Colorado		2,396		301	15	20		9	929		1,758	86	13,078	29	1,620			1,171
New Mexico		411	11	102	12	67	86	3	36		107	84	1,236	14	851		2	731
Arizona		1,390	2	212	4		1,342	11	456		5,348	236	3,316	16	1,471	11	8	1,293
Utah		4,084		13	2	3	2	1	752		7,804	93	8,454	17	3,038			316
Nevada		272	49	7		18	4	5			60	14	1,186	4	121			68
PACIFIC																		
Washington		4,509	115	338	10	62	99	31	903		277	30	12,394	94	4,385			831
Oregon		1,478	1	151	14		23	5			591	78	5,843	45	1,677			833
California	1	26,763	54	1,215	182	275		161	12,651		5,408	1,222	62,922	536	19,472			[3] 2,249
Total	36	225,020	1,104	16,423	4,073	24,164	6,456	664	59,151	15,236	284,138	47,916	681,184	5,597	159,654	1,445	3,891	104,098
Year 1945	44	284,625	1,329	18,606	3,341	34,672	11,125	673	29,222	16,194	511,489	61,707	144,398	8,035	196,317	1,571	3,837	108,777
Median 1941-45	75	299,985		16,421	3,220	30,872	9,421	673	130,417	16,194	476,275	58,917	612,068	8,035	198,264	1,627	4,809	129,021
Alaska		279	1	50		1	3		34		576		302		48			89
Hawaii Territory		888	20	17	14	52			1,368	8	11,874	[9] 149	734	16	257			[3] 124
Panama Canal Zone [10]		177		202	48	51						576	831	11	73			[11] 479

See footnotes on p. 408.

Consolidated monthly State morbidity reports for the year 1946—Continued

Division and State	Poliomyelitis*	Rabies in man	Rheumatic fever	Rocky Mountain spotted fever	Scarlet fever*	Septic sore throat	Smallpox*	Tetanus	Trachoma	Trichinosis	Tuberculosis, all forms*	Tuberculosis, respiratory	Tularemia	Typhoid fever*	Paratyphoid fever	Typhus fever, endemic	Undulant fever*	Vincent's infection	Whooping cough*
NEW ENGLAND																			
Maine	39				1,350	30		5		5	561	531		23	[13] 26		37	27	834
New Hampshire	184				739	107				6	191			8	1		33	35	381
Vermont	72				296	16					206			2	2		82	45	858
Massachusetts	380			1	6,103	178		12	1	38	3,255	3,068	2	36	177	3	53		6,516
Rhode Island	90		89		460	19		2		9	481	458		5	9		16	4	1,423
Connecticut	119				1,579	261		4		16	1,044	1,004		13	13		98		2,203
MIDDLE ATLANTIC																			
New York	1,424			16	17,018			32		151	13,366	12,682	6	154	27	16	300		9,032
New Jersey	256	2		17	4,191	151	2	9	2	19	3,621			60	29	3	54		7,034
Pennsylvania	287	3	820	20	9,347			11		3	3,787		6	191	[13] 23	3	116		6,464
EAST NORTH CENTRAL																			
Ohio	717	6	107	9	11,750	40	18	12	5	17	5,526		32	129	24	2	120	50	4,207
Indiana	433		1	12	2,871	197	42	11	2	1	2,730	2,602	77	107	5	1	167	38	1,155
Illinois	2,504	2	316	41	6,300	167	6	33	33	3	6,642	6,054	97	104	[13] 15		480	315	5,440
Michigan	1,081		358		5,976	288	3	26	1	8	5,546		21	92	[13] 84	[7] 2	136		8,116
Wisconsin	1,273				4,067	118	5		1		[7] 1,998		13	15	2		346		7,390
WEST NORTH CENTRAL																			
Minnesota	2,875		84	1	1,852	597	4	5			1,978		13	25	[13] 22		331	82	494
Iowa	634	1	17	2	1,690	93	15	2	1		761		3	48			638	9	1,042
Missouri	1,267		91	11	1,730	38	10				2,131		80	85	4	3	54		645
North Dakota	462		9		280	7	1		41	8	202	183	1	21			11	114	36
South Dakota	[7] 398			2	389	11			66		276	[13] 35		10			67	3	29
Nebraska	642				1,156		6				591		3	26	1		35		186
Kansas	1,046		5		2,055	28	10	9	15		783	769	37	28	3		271	153	1,069
SOUTH ATLANTIC																			
Delaware	32			16	246	1					196	196	2	15			3		183
Maryland	109		129	46	2,265	117		13		1	2,764	2,674	14	34	2	2	41	27	1,371
District of Columbia	36			4	572						2,620	2,537	6	30	3	1			383
Virginia	142			93	2,720	1,734		5	1		3,768	3,760	77	116	7	6	70		3,061
West Virginia	76			10	1,586	23	1				1,887		9	49	3		11		1,181
North Carolina	160			66	1,531	51	2				3,472	3,380	45	54	6	82	9		3,394
South Carolina	21		464	3	303	689		10		2	448		18	79	14	71	40		2,056
Georgia	170	1	30	33	500	256	3	15			1,992	1,975	60	80	65	595	169	102	564
Florida	570	1			285	146	2	40			2,119	2,109	4	68	[13] 115	420	96	119	996

EAST SOUTH CENTRAL																		
Kentucky	114			24	1,409	42	5	3	56		2,246	2,228	27	92	5	5	25	9	1,273
Tennessee	180	1	10	33	1,263	196	5	28	2	6	4,603		127	115	10	59	67	237	1,201
Alabama	378	3		6	785		5	38			3,567		16	64		417	102		1,112
Mississippi	335			1	541		9		84		2,248	2,202	68	100		119	132		7,198
WEST SOUTH CENTRAL																		
Arkansas	403	2		1	367	369	9	11	385	2	1,355	1,312	166	106	8	47	74		490
Louisiana	382		201	3	339	426	5	60	1		2,225	2,144	43	176	29	286	64		300
Oklahoma	403	2		28	541	164	16	6	287		2,479		30	51	4	5	36	18	462
Texas	979	3		4	2,194	1,653	28		125		6,322		42	443	61	1,147	750		8,443
MOUNTAIN																		
Montana	129		10	8	344	70	[14] 1	1	65		405	153	15	24			13	10	190
Idaho	48		68	7	369	227	17		14		217		8	28	45		23	89	452
Wyoming	123		1	14	271	67	4		2		32		11	10			4	21	206
Colorado	907		360	10	1,434	1,308	13		2		396			24	9		54	76	1,092
New Mexico	166		1		398	7	2	1	28		[7] 2,511	[7] 2,424		39	4	3	9		526
Arizona	109		3		461	2	1		329	1	1,406			49	5	1	34	4	707
Utah	143		88	4	953	5					180	165	28	2	[12] 5		35		718
Nevada	16		2		137	55	3		13		213		1	1			7	39	73
PACIFIC																		
Washington	522		320	4	1,383	106	88		1		2,262	[18] 279		46	10	1	51	652	1,556
Oregon	156		41	8	1,061	100	1	3	23		712	698		45	15		30		811
California	2,199		890	5	7,619	153	14	63	32	21	9,597	9,005	12	151	74	66	293		4,165
Total	25,191	27	4,515	563	113,076	10,313	356	470	1,618	317	117,910	64,627	1,220	3,273	[13] 966	3,366	5,687	2,278	108,718
Year 1945	13,514	25	4,781	452	174,128	10,112	345	439	1,448	258	115,299	67,786	856	4,221	716	5,180	4,959	3,273	132,814
Median 1941–45	12,429	29		448	142,274	7,787	746	426	2,603	307	115,299	67,786	887	[16] 4,947	[16] 675	4,517	3,639	1,939	191,112
Alaska	1				6	85					527	399	1	2				4	9
Hawaii Territory	25				30	80	[17] 1	8	2		1,477	1,126		9	11	89	4		27
Panama Canal Zone [10]	1				3						[11] 50			11	16	4			[11] 27

See footnotes on p. 408.

FOOTNOTES FOR TABLE ON PAGES 404 TO 407

*Diseases marked with an asterisk (*) are reportable by law or regulation in all the States, including the District of Columbia. Typhoid fever is reportable in all the States; paratyphoid fever in all except 6 States. Syphilis is reportable in all the States and the District of Columbia but is not included in the table. Some States have increased and some have reduced the list of reportable diseases since the latest published compilation of reportable diseases (Pub. Health Rep., Mar. 10, 1944. Reprint No. 2544).

[1] Includes cases of kerato- and suppurative conjunctivitis and of pink eye.
[2] In a few States practically all contracted outside continental United States.
[3] Lobar pneumonia only.
[4] Includes 1 case acquired through blood transfusion.
[5] New York City only.
[6] Acquired through blood transfusion.
[7] Includes nonresidents.
[8] For the month of January only.
[9] Includes off-shipping cases.
[10] Includes the cities of Colon and Panama.
[11] In the Canal Zone only.
[12] Includes cases of salmonella infections.
[13] For 3 months only.
[14] Removed from a troop train.
[15] For 2 months only.
[16] 4-year (1942–45) average.
[17] Off-shipping.

The following list includes certain rare conditions, diseases of restricted geographical distribution, and those reportable in or reported by only a few States; last year's figures in parentheses (where no figures are given, no cases were reported last year):

Actinomycosis: Connecticut 2 (3), Illinois 4 (1), Michigan 2 (5), Minnesota 12 (11), Iowa 3 (1), South Dakota 4, Tennessee 2, Montana 1 (1).
Beriberi: Florida 2.
Botulism: Tennessee 1, New Mexico 7, California 5 (25).
Coccidioidomycosis: New Mexico 2 (4), Arizona 17 (6), California 40 (39).
Colorado tick fever: Wyoming 3 (2), Colorado 31 (33).
Dengue: Maryland 1, North Carolina 1, South Carolina 10 (19), Georgia 1 (2), Florida 2, Mississippi 1 (10), Texas 21 (19), Wyoming 1, Arizona 1, Oregon 1.
Dermatitis: New Hampshire 15 (23), Ohio 1, Missouri 359 (357).
Diarrhea: New York 139, New Jersey 38 (6), Pennsylvania 32, Ohio 581 (1,159) (includes enteritis), Illinois 131 (2), Michigan 5 (15), North Dakota 6, Maryland 102 (136), South Carolina 9,995 (12,300), Florida 52 (42), Montana 1 (18) (includes enteritis), Idaho 1, Colorado 27 (6) (includes enteritis), New Mexico 140 (215), Utah 4 (27), Oregon 35 (6) (includes enteritis), California 160 (43), Alaska 4.
Dog bite: Illinois 12,545 (10,843) (all animal bites), Michigan 8,027 (8,389), Arkansas 697 (469).
Favus: Michigan 3 (1).
Filariasis: New Jersey 1 (2), Minnesota 1 (2).
Food poisoning: Maine 140 (7), New Jersey 6, Ohio 3 (1), Indiana 14 (9), Illinois 35 (105), Kansas 105, Louisiana 23 (22), Idaho 11 (2), New Mexico 2 (1), Nevada 6 (6), Washington 55 (78), Oregon 3, California 424 (483).
Framboesia (yaws): South Carolina 1.
Glanders: Tennessee 1.
Granuloma (unspecified): Ohio 44 (73).
Granuloma inguinale: Missouri 20 (13 , Florida 257 (244), Tennessee 98 (69), Mississippi 661 (618), Louisiana 300 (235), Arizona 3, Utah 2.
Impetigo contagiosa: New York 141, Ohio 29 (5), Indiana 100 (51), Illinois 43 (75), Michigan 1,304 (1,224), Iowa 1 (8), Missouri 5 (14), North Dakota 22 (5), Kansas 27 (55), Maryland 9 (38), Kentucky 14, Montana 41 (56), Idaho 65 (20), Wyoming 37 (25), Colorado 47 (50), Nevada 196 (121), Washington 936 (806), Hawaii Territory 27 (93).
Jaundice (including hepatitis and Weil's disease): Maine 19 (9), New York 409 (1), Pennsylvania 40, Ohio 6 (1), Indiana 63 (89), Illinois 90 (339), Michigan 33 (142), Minnesota 61 (16), Iowa 1 (15), North Dakota 7, Nebraska 2, Kansas 4 (80), Maryland 16 (20), South Carolina 6 (140), Florida 27 (23), Tennessee 7, Louisiana 4 (5), Montana 12 (7), Idaho 39 (40), Utah 23 (26), Washington 53 (84), Oregon 76 (20), California 279 (343). Alaska 4 (22), Hawaii Territory 9 (219).
Lead poisoning: Minnesota 1 (7), New Mexico 1 (1).
Leprosy: New York 2 (1), Illinois 1 (2), Michigan 2, Florida 8, Louisiana 4 (8), Texas 8 (5), Colorado 1, Washington 1 (1), California 7 (17), Hawaii Territory 33 (26), Panama Canal Zone 1.
Lymphocytic choriomeningitis: Massachusetts 4 (4), Tennessee 21 (31).
Lymphogranuloma venereum: Missouri 31 (25), Florida 175 (183), Tennessee 140 (87), Louisiana 106 (170), Utah 9 (6), Nevada 1.
Psittacosis: Massachusetts 2, New York 1 (4), Illinois 7 (2), Michigan 4, North Carolina 1, Washington 2, California 6 (3).
Puerperal septicemia: Ohio 1, Florida 3 (1), Tennessee 4 (2), Mississippi 239 (181), Louisiana 13 (36), New Mexico 3 (1), Nevada 3 (1).
Rabies in animals: Maine 1, New Hampshire 1, Massachusetts 2, New York 1,161 (576), Pennsylvania 6, Ohio 886 (785), Illinois 363 (421), Michigan 12 (35), Iowa 57 (69), Missouri 15 (35), Kansas 28 (15), Delaware 1, Maryland 30 (38), District of Columbia 4 (109), West Virginia 2, South Carolina 154 (131), Florida 62 (7), Alabama 712 (600), Arkansas 159 (184), Louisiana 45 (106), Texas 1,034 (838), Colorado 7, New Mexico 12 (10), Utah 12 (22), Oregon 1, California 402 (581).
Rat bite fever: Georgia 1, Tennessee 4 (1), Louisiana 1 (5).
Relapsing fever: Pennsylvania 3 (1), Texas 29 (18), Idaho 2, Arizona 2, Nevada 2 (16), California 17 (5), Panama Canal Zone 3.
Ringworm disease: Pennsylvania 1,543 (991), Ohio 185 (4), Indiana 488 (9), Illinois 1,891 (1,399), Michigan 1,385 (2,055) Minnesota 146 (691), Iowa 37 (8), Missouri 7 (112), Kansas 7 (23), Maryland 2, Montana 6 (11). Idaho 77 (9), Wyoming 2, Utah 250, Nevada 2 (13), Washington 689 (486).
Scabies: Rhode Island 2, Pennsylvania 567 (114), Ohio 18 (1), Indiana 1 (4), Michigan 1,241 (883), Missouri 41 (7), North Dakota 16 (27), Kansas 123 (93), Maryland 5 (28), Kentucky 25, Montana 73 (100), Idaho 203 (60), Wyoming 8 (7), Arizona 1, Nevada 74 (83).
Silicosis: Maine 1, New Hampshire 4, Idaho 3 (3), New Mexico 10 (6), Utah 1 (5).

WEEKLY REPORTS FROM CITIES [1]

City reports for week ended February 15, 1947

This table lists the reports from 91 cities of more than 10,000 population distributed throughout the United States, and represents a cross section of the current urban incidence of the diseases included in the table.

Division, State, and City	Diphtheria cases	Encephalitis, infectious, cases	Influenza		Measles cases	Meningitis, meningococcus, cases	Pneumonia deaths	Poliomyelitis cases	Scarlet fever cases	Smallpox cases	Typhoid and paratyphoid fever cases	Whooping cough cases
			Cases	Deaths								
NEW ENGLAND												
Maine:												
Portland	0	0	-----	0	-----	1	1	0	3	0	0	4
New Hampshire:												
Concord	0	0	-----	0	-----	0	2	0	1	0	0	-----
Vermont:												
Barre	1	0	-----	0	18	0	0	0	0	0	0	4
Massachusetts:												
Boston	9	0	-----	0	12	2	13	0	24	0	0	42
Fall River	0	0	-----	0	5	0	1	0	1	0	1	3
Springfield	1	0	-----	0	6	0	0	0	2	0	0	7
Worcester	0	0	-----	0	2	0	5	0	9	0	0	22
Rhode Island:												
Providence	1	0	-----	0	95	0	2	0	8	0	0	22
Connecticut:												
Bridgeport	0	0	-----	0	12	0	0	0	5	0	0	-----
Hartford	0	0	-----	0	1	0	0	0	3	0	0	-----
New Haven	0	0	-----	0	44	0	0	0	11	0	0	2
MIDDLE ATLANTIC												
New York:												
Buffalo	0	0	1	0	1	3	2	0	9	0	0	3
New York	10	1	12	1	65	6	66	0	128	0	2	38
Rochester	0	0	-----	0	5	0	1	0	10	0	0	1
Syracuse	0	0	-----	0	-----	0	5	0	8	0	0	8
New Jersey:												
Camden	1	0	-----	0	-----	0	1	0	6	0	0	-----
Newark	0	0	-----	0	-----	0	3	0	11	0	0	16
Trenton	0	0	-----	0	29	0	2	0	8	0	0	1
Pennsylvania:												
Philadelphia	3	0	3	0	4	2	25	0	53	0	0	41
Pittsburgh	0	0	-----	0	116	1	12	0	18	0	0	18
Reading	0	0	-----	0	2	0	1	0	3	0	0	3
EAST NORTH CENTRAL												
Ohio:												
Cincinnati	1	0	1	0	1	0	3	0	10	0	0	4
Cleveland	0	0	2	1	315	1	11	0	37	0	0	15
Columbus	1	0	1	1	1	0	2	0	7	0	0	10
Indiana:												
Fort Wayne	0	0	-----	0	6	0	3	1	0	0	0	1
Indianapolis	5	0	-----	1	-----	0	8	1	24	0	0	25
South Bend	0	0	-----	0	1	0	0	0	0	0	0	-----
Terre Haute	0	0	-----	0	-----	0	1	0	1	0	0	-----
Illinois:												
Chicago	0	0	1	0	38	5	37	0	62	0	0	46
Springfield	0	0	-----	0	-----	0	3	0	3	0	0	-----
Michigan:												
Detroit	2	0	-----	1	3	0	14	1	55	0	0	103
Flint	0	0	-----	0	-----	0	2	0	4	0	0	2
Grand Rapids	0	0	-----	0	1	0	3	0	5	0	0	7
Wisconsin:												
Kenosha	0	0	-----	0	-----	0	0	0	4	0	0	-----
Milwaukee	0	0	-----	0	9	0	7	0	10	0	0	40
Racine	0	0	-----	0	1	0	0	0	1	0	0	4
Superior	0	0	-----	0	-----	0	0	0	1	0	0	-----
WEST NORTH CENTRAL												
Minnesota:												
Duluth	0	0	-----	0	-----	0	0	0	0	0	0	-----
Minneapolis	1	0	-----	0	6	0	6	0	10	0	0	7
St. Paul	0	0	-----	0	10	0	3	0	4	0	0	2
Missouri:												
Kansas City	1	0	-----	0	-----	0	6	0	10	0	0	1
St. Joseph	0	0	-----	0	-----	0	0	0	0	0	0	2
St. Louis	3	0	3	1	3	0	13	0	6	0	0	5

[1] In some instances the figures include nonresident cases.

City reports for week ended February 15, 1947—Continued

Division, State, and City	Diphtheria cases	Encephalitis, infectious, cases	Influenza		Measles cases	Meningitis, meningococcus, cases	Pneumonia deaths	Poliomyelitis cases	Scarlet fever cases	Smallpox cases	Typhoid and paratyphoid fever cases	Whooping cough cases
			Cases	Deaths								
WEST NORTH CENTRAL—continued												
North Dakota:												
Fargo	0	0	------	0	------	0	1	0	0	0	0	------
Nebraska:												
Omaha	1	0	------	0	------	0	1	0	6	0	0	------
Kansas:												
Topeka	0	0	------	0	1	0	1	0	5	0	0	------
Wichita	1	0	------	0	------	0	4	0	3	0	0	4
SOUTH ATLANTIC												
Delaware:												
Wilmington	0	0	------	0	1	0	1	0	5	0	0	7
Maryland:												
Baltimore	4	0	3	1	6	1	11	1	15	0	0	52
Cumberland	0	0	------	0	6	0	1	0	0	0	0	------
Frederick	0	0	------	0	------	0	0	0	0	0	0	------
District of Columbia:												
Washington	0	0	2	1	13	0	6	1	13	0	0	8
Virginia:												
Lynchburg	0	0	------	0	------	0	0	0	0	0	0	5
Richmond	1	0	------	0	58	0	2	0	6	0	0	------
Roanoke	0	0	------	0	3	0	0	0	9	0	0	------
West Virginia:												
Charleston	0	0	------	0	------	0	0	0	3	0	0	------
Wheeling	0	0	------	0	------	0	1	0	1	0	0	2
North Carolina:												
Raleigh	0	0	------	0	1	0	0	0	0	0	0	------
Wilmington	1	0	------	0	3	0	3	0	0	0	0	------
Winston Salem	0	0	------	0	43	0	2	0	4	0	0	2
South Carolina:												
Charleston	0	0	13	0	2	0	2	0	0	0	0	------
Georgia:												
Atlanta	0	0	4	2	2	0	7	0	10	0	0	------
Brunswick	0	0	------	0	1	0	0	0	0	0	0	------
Savannah	0	0	1	0	50	0	1	1	0	0	0	3
Florida:												
Tampa	3	0	1	0	------	0	1	0	2	0	0	2
EAST SOUTH CENTRAL												
Tennessee:												
Memphis	1	0	------	0	3	0	11	0	9	0	0	10
Nashville	0	0	------	0	------	0	3	0	3	0	0	------
Alabama:												
Birmingham	0	0	1	1	------	0	5	0	3	0	0	------
Mobile	0	0	------	0	4	0	2	0	0	0	0	------
WEST SOUTH CENTRAL												
Arkansas:												
Little Rock	0	0	------	0	2	0	1	0	0	0	0	3
Louisiana:												
New Orleans	3	0	16	2	3	2	4	0	1	0	3	------
Shreveport	0	0	------	0	------	0	4	0	0	0	0	------
Oklahoma:												
Oklahoma City	1	0	1	0	1	1	3	0	6	0	0	------
Texas:												
Dallas	0	0	1	1	------	0	0	0	1	0	0	9
Galveston	0	0	------	0	------	0	2	0	2	0	1	1
Houston	0	0	------	0	------	0	3	0	0	0	0	------
San Antonio	2	0	------	1	------	0	7	1	0	0	0	4
MOUNTAIN												
Montana:												
Billings	0	0	------	0	------	0	3	0	0	0	0	------
Great Falls	0	0	------	0	175	0	0	0	0	0	0	------
Helena	0	0	------	0	15	0	0	0	0	0	0	1
Missoula	0	0	------	0	------	0	0	0	2	0	0	------
Idaho:												
Boise	0	0	------	0	------	0	1	0	0	0	0	------
Colorado:												
Denver	6	0	37	1	10	1	8	0	22	0	0	7
Pueblo	1	0	------	0	------	0	0	0	8	0	0	------
Utah:												
Salt Lake City	0	0	------	0	4	0	0	0	4	0	0	------

City reports for week ended February 15, 1947—Continued

Division, State, and City	Diphtheria cases	Encephalitis, infectious, cases	Influenza		Measles cases	Meningitis, meningococcus, cases	Pneumonia deaths	Poliomyelitis cases	Scarlet fever cases	Smallpox cases	Typhoid and paratyphoid fever cases	Whooping cough cases
			Cases	Deaths								
PACIFIC												
Washington:												
Seattle	1	0	------	1	1	0	6	0	6	0	0	3
Spokane	0	0	------	0	------	0	1	1	5	0	0	------
Tacoma	0	0	------	0	2	0	0	0	0	0	0	4
California:												
Los Angeles	14	0	5	0	4	0	2	6	22	0	0	23
Sacramento	0	0	------	0	1	1	0	0	3	0	0	4
San Francisco	2	0	1	1	1	1	5	1	22	0	0	1
Total	82	1	110	18	1,228	28	380	15	776	0	7	664
Corresponding week, 1946*	115	------	244	41	6,089	------	502	------	1,000	0	12	501
Average 1942–46*	74	------	244	[3] 49	[3] 4,208	------	[3] 490	------	1,521	1	11	710

[3] 3-year average, 1944–46. [3] 5-year median, 1942–46. *Exclusive of Oklahoma City.

Anthrax.—Cases: Camden, 1.
Dysentery, amebic.—Cases: Boston, 1; New York, 3; Philadelphia, 3; St. Louis, 1; Memphis, 2.
Dysentery, bacillary.—Cases: New York, 2; Detroit, 1.
Dysentery, unspecified.—Cases: San Antonio, 5.
Tularemia.—Cases: Washington, D. C., 1.
Typhus fever, endemic.—Cases: New York, 1; Charleston, S. C., 1; Tampa, 3; Mobile, 1; Los Angeles, 2.

Rates (annual basis) per 100,000 population, by geographic groups, for the 91 cities in the preceding table (latest available estimated population, 34,631,100)

	Diphtheria case rates	Encephalitis, infectious, case rates	Influenza		Measles case rates	Meningitis, meningococcus, case rates	Pneumonia death rates	Poliomyelitis case rates	Scarlet fever case rates	Smallpox case rates	Typhoid and paratyphoid fever case rates	Whooping cough case rates
			Case rates	Death rates								
New England	31.4	0.0	0.0	0.0	510	7.8	62.7	0.0	175	0.0	2.6	277
Middle Atlantic	6.5	0.5	7.4	0.5	103	5.6	54.6	0.0	118	0.0	0.9	60
East North Central	5.5	0.0	3.0	2.4	229	3.6	57.2	1.8	136	0.0	0.0	156
West North Central	13.9	0.0	6.0	2.0	40	0.0	69.6	0.0	88	0.0	0.0	42
South Atlantic	14.7	0.0	39.2	6.5	309	1.6	62.1	4.9	111	0.0	0.0	132
East South Central	5.9	0.0	5.9	5.9	41	0.0	123.9	0.0	89	0.0	0.0	59
West South Central	15.2	0.0	45.7	10.2	15	7.6	61.0	2.5	25	0.0	10.2	43
Mountain	55.6	0.0	293.9	7.9	1,620	7.9	95.3	0.0	286	0.0	0.0	64
Pacific	26.9	0.0	9.5	3.2	14	3.2	22.1	12.7	92	0.0	0.0	55
Total	12.4	0.2	16.6	2.7	185	4.2	57.4	2.3	117	0.0	1.1	100

TERRITORIES AND POSSESSIONS

Puerto Rico

Notifiable diseases—4 weeks ended January 25, 1947.—During the 4 weeks ended January 25, 1947, cases of certain notifiable diseases were reported in Puerto Rico as follows:

Disease	Cases	Disease	Cases
Chickenpox	33	Poliomyelitis	20
Diphtheria	41	Syphilis	181
Dysentery, unspecified	5	Tetanus	10
Gonorrhea	146	Tuberculosis (all forms)	543
Influenza	97	Typhoid fever	12
Malaria	322	Typhus fever (murine)	3
Measles	10	Whooping cough	62

FOREIGN REPORTS

CANADA

Provinces—Communicable diseases—Week ended February 1, 1947.—During the week ended February 1, 1947, cases of certain communicable diseases were reported by the Dominion Bureau of Statistics of Canada as follows:

Disease	Prince Edward Island	Nova Scotia	New Brunswick	Quebec	Ontario	Manitoba	Saskatchewan	Alberta	British Columbia	Total
Chickenpox		15	2	240	322	19	38	37	78	751
Diphtheria	1	4		23	7	1		2		38
Dysentery:										
Amebic					6					6
Bacillary									4	4
German measles					23	2		5	7	37
Influenza		2			12	4			2	20
Measles		132	2	91	70	174	102	238	506	1,315
Meningitis, meningococcus			1	2	2	1			1	7
Mumps		1	1	95	568	38	183	31	221	1,138
Poliomyelitis				4	1					5
Scarlet fever		7	1	82	83	9	1	2	9	194
Tuberculosis (all forms)		14	29	63	18	7	12	5	32	180
Typhoid and paratyphoid fever		1		6	1					8
Undulant fever				1	4			4	3	12
Venereal diseases:										
Gonorrhea		18	13	152	110	32	20	56	81	482
Syphilis	3	12	5	81	83	16	15	14	35	264
Other forms							1			1
Whooping cough		4	3	36	69	16	13	7	12	160

REPORTS OF CHOLERA, PLAGUE, SMALLPOX, TYPHUS FEVER, AND YELLOW FEVER RECEIVED DURING THE CURRENT WEEK

NOTE.—Except in cases of unusual incidence, only those places are included which had not previously reported any of the above-mentioned diseases, except yellow fever, during recent months. All reports of yellow fever are published currently.

A table showing the accumulated figures for these diseases for the year to date is published in the PUBLIC HEALTH REPORTS for the last Friday in each month.

Cholera

Indochina (French)—Cambodia.—For the month of January 1947, 230 cases of cholera with 147 deaths were reported in Cambodia, French Indochina.

Smallpox

Indochina (French).—For the month of January 1947, 373 cases of smallpox with 152 deaths were reported in French Indochina.

Typhus Fever

Bulgaria.—For the period January 15–21, 1947, 43 cases of typhus fever with 6 deaths were reported in Bulgaria.

Eritrea.—For the week ended February 1, 1947, 30 cases of typhus fever with 5 deaths were reported in Eritrea.

Rumania.—For the week ended January 25, 1947, 400 cases of typhus fever, including 14 cases reported in Bucharest, were reported in Rumania.

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FEDERAL SECURITY AGENCY

UNITED STATES PUBLIC HEALTH SERVICE

THOMAS PARRAN, *Surgeon General*

DIVISION OF PUBLIC HEALTH METHODS

G. ST. J. PERROTT, *Chief of Division*

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It contains (1) current information regarding the incidence and geographic distribution of communicable diseases in the United States, insofar as data are obtainable, and of cholera, plague, smallpox, typhus fever, yellow fever, and other important communicable diseases throughout the world; (2) articles relating to the cause, prevention, and control of disease; (3) other pertinent information regarding sanitation and the conservation of the public health.

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